CONSENT TO PHOTOGRAPH

I, _____, a current resident/tenant/patient
(Resident/Tenant/Patient)

at/of _____ hereby authorize
(Facility/Residence/Agency)

the attending physician or other designated person(s) to take:

1. Photographs of me for identification purposes. ❍ Yes ❍ No

2. Photographs of appropriate parts of my body in order to provide supporting documentation of my medical condition. *(I understand that any photographs taken will be placed in and remain part of my medical record.)* ❍ Yes ❍ No

3. Photographs of me for the purpose of (specify): ❍ Yes ❍ No

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Resident/Tenant/Patient Signature_____ Date_____

Responsible Party Signature_____ Date_____

Relationship to Resident/Tenant/Patient _____

Witness Signature_____ Title_____ Date_____

NAME–Last	First	Middle	Attending Physician	ID No.