**Patient Photography Consent**

For the purposes of accurate record keeping in connection with the care and treatment which I am receiving and will subsequently receive from this clinic, I consent to have this clinic’s staff take before, during, and/or after treatment close-up photographs of the involved area(s) and the anatomical region surrounding the involved area(s). These photographs shall be used for medical records and audit and shall be treated with the same confidentiality as the remainder of my record at this clinic. I consent to the taking of photographs and authorize their anonymous and discretionary use for the purposes of education, service promotion, social media marketing, and for medical audit as a requirement of the provider's professional insurance.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_