Marshall
Wound Healing Center

CONSENT TO PHOTOGRAPH

I hereby authorize and consent to the making of photographs of me while I am a patient at _____Wound Healing Center. I understand that the photographs may be made by the Center, by my attending physician or an agent or employee of the Center. I understand that such photographs may be used for treatment purposes, including the assessment and evaluation of my wound. I hereby consent to such use of photographs, and release this wound healing center, my physician, and agents and employees of this center from all liability related to the making and use of such photographs.

PATIENT'S SIGNATURE:

_____

WITNESS SIGNATURE:

_____

NOTE: When the patient is a minor or otherwise legally incompetent, the legal guardian has the authority to authorize medical services. However, any minor patient who can understand this form should be given the opportunity to sign it in addition to the legal representative.

SIGNATURE OF PATIENT'S LEGAL REPRESENTATIVE:

_____

RELATIONSHIP: _____

WITNESS:

_____

Patient Label: