# PATIENT CONSENT
# TO RELEASE MODELS & PHOTOGRAPHS

Date:_____

Doctor:_____

Address: _____

_____

_____

_____

For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by you, or anyone authorized by you, of any and all photographs which you have this day been taken of me, negative or positive, proofs of which are hereto attached for any purpose whatsoever, without further compensation to me. All negatives and positives, together with the prints shall constitute your property, solely and completely.

I am over 19 years of age: Yes_____ No_____

Patient Name: _____

Patient Address: _____

_____

_____

Patient Signature: _____

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If the patient is under the age of 19 years, a parent or guardian should give consent as follows:

I hereby certify that I am the parent or guardian of _____ _____, the model for whom named above, and for value received I do give my consent without reservations to the foregoing on behalf of him or her or them.

Date: _____

Print Name: _____
*(Parent / Guardian)*

Signature: _____