CONSENT FOR PHOTOGRAPHS OR VIDEO

In connection with medical services I am receiving from Dr. Caster, I authorize photography or video imaging to be taken of me or clinically relevant parts of my body for medical records only, unless other uses are indicated below by my initials.*

Patient Printed name: **____

Patient Signature: **____

Patient's Agent/Representative's Signature: _____________________________________

Relationship to Patient: ____

Date: _______________________________ Time: _______________________

*________ By initialing here, I consent to use of my photographic or video images in a professional manner for publication, patient education, public seminar/display or promotional activities such as marketing, advertising, etc., including social media such as Facebook or similar outlets.

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