St.JosephHealth
Medical Group

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CONSENT AND RELEASE FOR MEDICAL PHOTOGRAPHS

I, _____, do hereby authorize the physicians of St. Joseph Health Medical Group, to photograph or permit other persons to photograph for designated medical purposes.

These photographs will only be used for documentation and diagnosis of disease. I understand that every effort will be made to minimize the possibility of my being identified, but that in some instances such identification cannot be avoided.

I agree not to hold St. Joseph Health Medical Group, its officers, agents, and employees responsible for any liability resulting from the taking, publication and release of such photographs.

Signature _____ Date _____

If the patient is an unemancipated minor or unable to sign, complete the following:

❒ Patient is an unemancipated minor

❒ Patient is unable to sign

Parent or Legal Representative_____
Witness _____ Date_____