

## **Consent to Photograph**

The undersigned hereby authorizes

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(Name of Organization)

and the attending physician to photograph or permit another person in the employ of this facility to photograph

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(Name of Patient)

while under the care of this facility, and

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(Name of Patient or legal guardian)

agrees that the negatives or prints be stored in the client's medical record, sealed in a separate envelope, so that they may be used later for evidence. these photographs will be released only to the police or the prosecutor when the undersigned gives permission to release the medical records or in case of a court order. the undersigned does not authorize any other use to be made of these photographs.

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(Date)

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(Signature of Patient or Legal Guardian)

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(Name and signature of witness)

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(Street Address of Patient)

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(City)

(State)

(Zip Code)