

SOUTHEAST VALLEY OBSTETRICS AND GYNECOLOGY, PLC

480-464-2101

CONSENT TO PHOTOGRAPH

The undersigned hereby authorizes Southeast Valley OB/GYN to photograph

_____ and agrees that the
(Name of patient)

negative, prints or digital picture be stored in the patient's medical record. These photographs will be released only when the undersigned gives written permission to release the medical records or in the case of a court order. The undersigned does not authorize any other use to be made of these photographs.

Date

Signature of Patient or Legal Guardian