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Photo Consent

Medical Photo Consent

I hereby give Dr. Tamara Kurmanalieva and the staff the absolute permission to photograph myself, for the medical reason(s) indicated at my consultation, and for pre and post assessment care, only.

Name (please print): _____

Signature _____ Date _____

Photo Release

I hereby give Dr. Tamara Kurmanalieva and staff the absolute right and permission to copyright and/or publish, or use photographic portraits of me, or in which I may be included in whole or in part, or reproductions thereof in color or otherwise, for presentations, photo albums, display on the company's web site, art trade, news or any other lawful purpose whatsoever. I hereby waive any right that I may have to inspect and/or approve the finished product or the advertising copy that may be used in connection therewith, or the use to which it may be applied.

Name (please print): _____

Signature _____ Date _____

Photo Albums Website Talk with other patients

Parent or guardian of a minor

I, the undersigned, being the parent or guardian of _____ do hereby consent and/or release photos for the stated purpose above, and signature thereto.

Name (please print): _____

Signature _____ Date _____