

GEORGE P. CHATSON, M.D.

CONSENT TO BE PHOTOGRAPHED

Patient Name: _____ Date: _____

In connection with the medical services which I am receiving from Dr. Chatson, I consent that photographs may be taken of me or of parts of my body, under the following conditions:

- 1) The photographs shall be taken by Dr. Chatson or by a competent photographer, approved by Dr. Chatson.

- 2) These photographs shall be used for insurance purposes and/or medical records only, unless in the judgment of my physician, medical research, education, or science would benefit in their use; in that event, I allow that they may be used for scientific and teaching purposes with the understanding that my name shall be omitted in the use of the photographs.

Patient Signature

Parent/Guardian