CONSENT TO PHOTOGRAPH for Clinical Practice and Cases in Emergency Medicine

The undersigned hereby authorizes the ___________ Medical Center, and the attending physician to photograph or permit other persons to photograph __________________________________________________________

Name of Patient while under the care of the ___________ Medical Center, and agrees that the negatives or prints prepared therefrom may be used for such purposes and in such manner as may be deemed necessary, except for the following:

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

The undersigned hereby agrees to hold harmless the ___________ Medical Center, its officers, agents and employees, from any liability result from or arising in connection with the taking, publication in Clinical Practice and Cases in Emergency Medicine and release of photographs of the patient pursuant to this agreement.

____________________________________
Signature of patient/parent/guardian

___________________________________
Relation if other than patient

____________________________________
Signature of witness

____________________________________
Date and Hour