Consent to Photograph

The hereby authorizes Dr. Frank Alexander to photograph or permit other staff to photograph:

Name_____________________________________Date of Birth_________

While under the care of Dr. Frank Alexander, I agree that they may use the photographs prepared for the following purposes.
(Check all that apply)

Identification	Yes_____	No_____
Educational	Yes_____	No_____
Treatment/Services	Yes_____	No_____
Insurance	Yes_____	No_____
Publication	Yes_____	No_____

Name____Date____________

Witness______________________________________Date____________