Heritage Corner
Health Care Campus

Consent to Photograph

I, _____, a current client at/of Heritage Corner Health Care Campus, hereby authorize Heritage Corner, attending physician, or other designated person(s) to take:

1.) Photographs of me for identification purposes. ☐ Yes ☐ No

2.) Photographs of appropriate parts of my body in order to provide supporting documentation of my medical condition. (I understand that any photographs taken will be placed in and remain part of my medical record.) ☐ Yes ☐ No

3.) Photographs of me for the purpose of the Heritage Corner newsletter, Heritage Corner advertising, and for the purpose of (specify): ☐ Yes ☐ No

_____
_____
_____

_____ _____
Client Signature Date

_____ _____
Responsible Party Signature Date

_____ _____
Heritage Corner Representative Date