DeLuke Dermatology
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Photography Consent Form

DeLuke Dermatology is committed to providing high-quality healthcare to its patients. As such, the use of clinical photography is limited to the purposes of diagnosis, treatment, and professional education. This policy establishes guidelines for managing multimedia imaging of patients. For the purpose of this policy, multimedia imaging includes photography, videotaping, and audiotaping. Use of these medias will be carefully controlled and executed in compliance with all state and federal regulations as well as other organizational policies and procedures.

I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journals. By consenting to these medical photographs I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may do so by informing the office.

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Patient and/or Guardian Signature Date

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Print Name Relationship (if applicable)