California Heart & Vascular Clinic

CONSENT TO PHOTOGRAPH OR VIDEO

Patient: _____ Time: _____ ☐ AM ☐ PM

Date of Birth: _____

MRN: _____

I authorize _____ (provider) to photograph or video or permit other persons to photograph or video _____(patient). I agree that the provider or attending physician may use or permit other persons to use the negatives or prints as prepared for treatment purposes and in such manner as may be deemed necessary.

_____ _____

Patient Signature Date

_____ _____

Signature of Legally Authorized Representative Relationship to Patient

_____ _____

Witness Date