

**Consent for Photography, Videotaping, or Other Imaging
for Media or Educational Purposes**

Patient's Name: _____

Patient's Date of Birth: _____

I give my consent to have photographs, videotaped images, or other images taken of
I understand and agree that these images may be used by [name of practice] for the purpose outlined below.

_____ Teaching purposes, which includes being shown to other patients.

_____ Advertisements by Precision Foot and Ankle Clinic

_____ Placement on Precision Foot and Ankle Clinic's website

_____ Other _____

Signature of patient/legal representative

If legal representative, relationship to patient

Date