CONSENT FOR MEDICAL PHOTOGRAPHY

I consent for medical imaging (phone, video, and/our audio) to be made of me, my child, or the person whom I am a legal guardian for. I understand that the information may be used in my/their medical record, for purposes of medical teaching at Witte Physical Therapy, or for publication in marketing tools in print or on Witte Physical Therapy social media accounts (Facebook, Twitter, Instagram). By consenting to this medical photography, I understand that I will not receive payment from any party. Refusal to consent to photographs, video, and/or audio recordings 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 contact the staff at Witte Physical Therapy.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, AND IS THE PATIENT, OR IS DULY AUTHORIZED BY OR IN BEHALF OF THE PATIENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

Responsible Patient/Party/Insured: _____

Responsible Patient/Party/Insured: _____

Witness: _____

Date and Time: _____