Medical Photo Consent Form

The patient below authorizes **Jackson Regional Women's Center** to use medical images and/or video of themselves or their child. The images may be:

1. Placed in medical record for future treatment
2. Electronically emailed to my treating health professional
3. Used by physician for education and training
4. Used in paper or electronic health publications
5. Commercial broadcast use
6. Available for marketing materials

The photography that a patient brings to the office for public display is also included in this consent**. JRWC's** Facebook page will display your child once this consent is signed and dated if you send photos to the page.

Such photographs, ads, brochures, and other materials sent by a patient will become the sole and separate property of **JRWC**, or the media preparing them. This consent involves no financial consideration to either party.

A photocopy of this authorization shall be considered as effective as the original.

By signing below, I confirm I understand this consent form.

Date: _____

Signature: _____

Printed Name: _____

Address: _____

_____

Phone: _____