Desai Medical Center
3290 N. Ridge Rd., Suite 100
Ellicott City, MD 21043
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Patient Consent to Medical Photography

Today's Date: _____

Last Name	
First Name	
DOB	

I, _____, hereby authorize Desai Medical Center to take medical photographs of me before, during, or after treatment.

I understand that the photographs will be part of my medical records and may also be used for the following reasons:

- Communication with other health care professionals
- Student education
- Educational publications
- Educational lectures

I understand that if my medical photographs are used for educational purposes, they will be used without my personal health information (PHI) to protect my privacy and confidentiality.

I understand that I will not receive any compensation, financial or otherwise, for the use of my medical photographs.

By signing below, I certify that this consent form has been explained to me in terms which I understand.

_____ _____

Print Date

_____ _____

Signature Date