Mountain West Dermatology, PC

CONSENT FOR PHOTOGRAPHY

I, _____, by signing this form on the line below authorize Mountain West Dermatology, P.C., its employees, agents, and medical staff to record or document examinations, medical procedures, and other images of me through the means of photography, videotape, audiotape, motion picture, or digital imaging, and any other later developed mediums which result in the permanent documentation of the patient's image for the following uses and purposes:

Use in connection with my care and treatment and for the purposes of supporting documentation for insurance company claims or authorizations.

I agree that my photographs taken by Mountain West Dermatology, P.C., which are not required by law to be retained, may be disposed of by Mountain West Dermatology, P.C., provided the manner of disposition shall be permanent destruction.

I hereby waive all rights and release Mountain West Dermatology, P.C. from any claim or cause of action, whether now known or unknown, for defamation, invasion of right to privacy, publicity or personality or any similar matter, or based upon or relating to the use and exploitation of my name, image, and likeness in connection with the aforementioned advertising and publicity materials.

This consent may be revocable by me at any time.

_____ _____ _____

Patient/Legal Representative Print Name Date