WHITE SANDS PODIATRY
FOOT AND ANKLE SURGERY CENTER

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 made of._____ I understand and agree that these images may be used by White Sands Podiatry, for the purpose outlined below.

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

_____ Advertisements by White Sands Podiatry

_____ Placement on White Sands Podiatry's website

_____ Other

_____

_____
Signature of patient/legal representative

If legal representative, relationship to patient _____

_____
Date