Charleston
Wound Care

Consent for Photography

I hereby authorize and consent for photographs of me and/or my wound to be taken while I am a patient at Charleston Wound Care. I understand that the photographs may be taken by my attending physician or any employee of Charleston Wound Care. I further understand that such photographs may be used for the assessment and evaluation of my wound as well as educational purposes and may be published, shown, exhibited or otherwise used by Charleston Wound Care as they deem proper. I hereby consent to such use of photographs and release Charleston Wound Care, my physician and employees of Charleston Wound Care from all liability related to the taking and use of such photographs.

Patient Signature

_____

Date / Time:

_____

Witness Signature

_____

Date / Time:

_____

When the patient is a minor or otherwise legally incompetent, the legal guardian has the authority to authorize medical services. However, any minor patient who can understand this form should be given the opportunity to sign it in addition to the legal representative.

Signature of Legal Representative

_____

Date / Time:

_____

Witness Signature

_____

Date / Time:

_____

Relationship with Patient:

_____

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