SUMMIT
SKIN & VEIN CARE
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PHOTO CONSENT:

I acknowledge the importance of documenting my care with before and after photos and give permission for Summit Skin and Vein Care to do so.

I understand that my photographs may be used for insurance companies, educational, training and/or marketing purposes without gratuity and that reasonable attempts to conceal my identity will be made. No listing of my name will be shown. Cropping of the picture will be performed to show primarily the affected areas.

Patient Signature: _____ Date:_____

Patient Name (Print):_____ DOB:_____

Witness Signature: _____ Date: _____