Cosmetic Dermatology Center
Nicole Hayre, MD
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(703) 827-8600

Consent for Photographic Documentations

I understand that photographic documentation is an integral part of Dr. Hayre's practice. I consent to photos being taken and understand that they will be kept with my medical records. I am aware that Dr. Hayre receives many requests to give educational speeches and to publish her findings in medical journals. I consent to my photos being used as educational material. I also understand that every effort will be made to conceal my identity.

Please check one:

☐ I consent to photos being taken for the purpose of my medical record only.

☐ I consent to photos being taken for the purpose of my medical record and possible medical publication. I also understand that every effort will be made to conceal my identity.

_____
Signature of patient or guardian

_____
Printed Name

_____
Date

_____
Witness's signature

_____
Printed Name

_____
Date