ONESKIN DERMATOLOGY

CONSENT TO PHOTOGRAPH

I consent for medical or cosmetic photographs to be taken of me by the staff or representatives of OneSkin Dermatology. I understand that the images will be placed in my medical record and may be used for evaluation by employees of OneSkin Dermatology. By consenting to these medical photographs, I understand that I will not receive payment from any party. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me.

I also give permission for transfer of these photographs via a non-encrypted email exclusively for the purposes of third-party diagnostics, treatment and continuing medical care (e.g.communication with my primary care physician).

Refusal to consent to photographs will in no way affect the medical care I will receive. If I wish to withdraw my consent in the future, I may do so with a written request.

____ I acknowledge that I have reviewed and understand this consent.

Patient Name: _____ Date of birth: ___/___/_____

Patient Signature _____ Date: ___/___/_____

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