Joseph W. Aguiar, MD, PA
8557 W. Linebaugh Ave
Tampa, FL 33625
813-739-0915
813-739-0917

Patient's Consent to Be Photographed

Date: ____________________________

Patient's Name: ____

In connection with the medical services I am receiving from Dr. Joseph Aguiar, I consent that photographs may be taken of me or parts of my body, under the following conditions:

1. The photographs may be taken only with the consent of my physician under such conditions and at such times as may be approved by him.

2. The photographs shall be taken by my physician or by photographer approved by my physician.

3. The photographs shall be used for medical records and if in judgment of my physician, medical research, education or science will benefit by their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals, websites or medical books, or used for any other purpose which he may deem proper in the interest of medical education, knowledge, or research; provided, however that is specifically understood that in any such publication or use I shall not be identified by name.

____

Signature of Patient or Legal Custodian Date

____

Witness Date