Center for Women's Health

ADVANCED AND PERSONALIZED CARE FOR WOMEN
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Photo Consent Form

Center for Women's Health would like your permission to take and use images of you and your family on our website (mywomensdoc.com) and on our social media sites such as Facebook, Twitter, etc. Please read the following disclosure and sign below.

I grant Center for Women's Health and its affiliates the right to take photographs of me and my family in connection with the above-identified event. I agree that Center for Women's Health may use and publish such photographs of me and my family with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content. I understand that I will not receive any form of compensation by any party involved in the use of my photos and that if I wish to withdraw my consent that I may do so in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

By signing below, I agree to the terms of this consent and give my permission to the use of me and my family's photos taken by Center for Women's Health and its affiliates for the purposes stated above.

Patient Name _____

If Minor, Name of Legal Guardian _____

Signature _____ Date ____/____/____

☐ Check here if you **DO NOT** give consent to the use of you or your family's photos.

Patient Name _____

If Minor, Name of Legal Guardian _____

Signature _____ Date ____/____/____

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