Peripheral Vascular Associates
DOCTORS OF ARTERIES & VEINS

Authorization to Photograph/Videotape

You have the option to allow photography to be taken during your visit today. If you agree to allow this photography, the doctor or designated representative may videotape or use other imaging (for example digital or standard photographs) during your visit. The videotape/photographs will be used as part of your medical record.

There are no additional risks of benefits associated with the photography.

There will be no cost to you for allowing the photography. You will not be paid for allowing the photography.

You are not waiving any of your legal rights by signing this authorization.

This authorization is entirely voluntary.

I have read and understand this consent form and the description of the authorization. I am voluntarily signing this form as proof of my decision to authorize photography of myself. I understand that I, or my legally authorized representative, will be given a copy of the signed consent form.

Printed Name	Signature	Date
Printed Name of Legally Authorized Representative	Signature of Legally Authorized Representative	Date
Printed Name of Person Obtaining Consent	Signature of Person Obtaining Consent	Date