KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Kaiser Foundation Hospitals
The Permanente Mecical Group, Inc.

MR#: _____

Name: _____

CONSENT TO PHOTOGRAPH FOR TREATMENT/ STUDY/EDUCATION/RESEARCH/OBSERVATION

IMPRINT AREA

PATIENT NAME	MEDICAL RECORD NUMBER

I hereby consent to be photographed while receiving treatment at Kaiser Permanente. The term “photograph” includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

I hereby authorize the use of the photograph(s) for the following purposes only: for medical study, education, research, observation, or other medical purposes.

Write member’s/patient’s name, medical record number, and date on each photo. Tape (do not staple) photo(s) to this form and place in member’s/patient’s medical record or submit for scanning into HealthConnect per facility protocol.

SIGNATURE (PATIENT, PARENT, LEGAL REPRESENTATIVE)	DATE	TIME
WITNESS*	DATE	TIME

Any adult who can acknowledge that the member/patient (or member’s/patient’s legal representative) signed this form

DISTRIBUTION: WHITE = CHART • CANARY = MEMBER/PATIENT