Hyperbaric Medicine Inc.
OF FLORIDA

CONSENT AND RELEASE FOR PHOTOGRAPHIC DOCUMENTATION

I do hereby authorize HYPERBARIC MEDICINE, INC. and Dr. Albert Zant and Associates and Assistants to administer Hyperbaric Oxygen Therapy for my medical condition identified in the Patient Record produced and maintained by HYPERBARIC MEDICINE, INC.

I do hereby consent that photographic and/or video images be taken of me (Print Name) _____ , and give ownership of all images to Hyperbaric Medicine, Inc. All images consented to and released by me shall be used according to following guidelines:

1. Photographic and/or Video images may only be taken with the consent of the Hyperbaric Physician and at such a time as may be approved by him/her.

2. All images shall be used for medical records and if in the judgment of the Hyperbaric Physician all images are allowed to be used for medical education, medical research, and advertising.

3. All pertinent patient information regarding my medical condition may be published or republished either separately or in connection with other information including but not limited to professional journals, medical books, and/or transmitted by television or other devices for viewing or used for any other purpose which may be deemed proper in the interest of medical education, knowledge or research; provided that it is specifically understood that in any such publication or use I shall not be identified by name.

AUTHORIZING SIGNATURE

Patient is alert and oriented to time and place _____ *Physician*

Patient Signature _____

Authorized Agent _____

Witnesses _____

Address _____

Witnesses _____

Address _____

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