



**CONSENT TO PHOTOGRAPH**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
(please print)

I, the undersigned, do hereby authorize The Vein Center's physicians and/or authorized employees of The Vein Center to photograph my leg(s) for the treatment of varicose veins, while I am under their care.

I agree that they may use or permit other persons to use the negatives or prints prepared there from, for insurance purposes.

The Vein Center may utilize the pictures for publication in medical literature and/or educational purposes (without identifying the patient).

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date