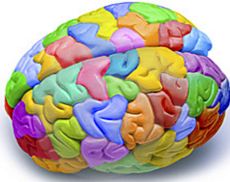
Shannon E. Taylor PhD PA

North Texas Neuropsychology and Behavioral Medicine Services



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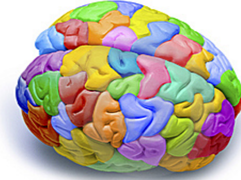

INFORMED CONSENT TO PHOTOGRAPH

Date:_______________________________________

I, ____, due hereby give consent for North Texas Neuropsychology and Behavioral Medicine Services, Dr. Taylor or staff to take photograph(s) of

____.

I understand the photograph will be used for identification purposes only and contained within the confidential file of the child/patient.

Print Name:____

Signature:____

Relation to Patient:____