

# Shannon E. Taylor PhD PA

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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: \_\_\_\_\_