

# AUTHORIZATION FOR MEDICAL PHOTOGRAPHY

## SPOKANE, WASHINGTON

I, the undersigned, hereby authorize Dr. Carol Hathaway to take photographs of me as may be necessary or desirable for the proper and efficient medical care of my case.

I further understand that such photographs are to be the sole property of Dr. Carol Hathaway and may not be exhibited or shown by said doctor to medical, non-medical groups, and /or individuals in the interest of medical science without special authorization from me.

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Signature

Date this \_\_\_\_\_ day of \_\_\_\_\_, 201 \_\_\_\_.