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.

_____

Signature

Date this_____day of _____, 201___.