

SPRING HILL Pediatric Care



I, _____ would like to grant my permission and voluntarily grant Spring Hill Pediatric Care to take a picture of me or/and my child at the time of my office visit solely for the purpose of identification in the electronic medical records.

I understand that I may revoke this authorization at any time by notifying Spring Hill Pediatric care in writing.

I also understand that consent to have my picture taken is voluntary and if I refuse to this consent, it will have no effect on my health care.

Patient's name

Parent / Guardian's signature

Date