SPRING HILL
Pediatric Care

I, ____________________________ would like to grant my permission and voluntarily grant Spring Hill Pediatric Care to take a picture of me and my child/children 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**

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Patient's name

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Patient's name

______________________________ ______________________________
Patient's name **Date**