
655 Africa Road
Westerville, Ohio 43082

# CONSENT TO PHOTOGRAPH

I, _____ hereby consent to the taking of photography, audio/visual recording or other images of me by Central Ohio Primary Care Physicians, INC (COPCP). I understand that my photographs, videotapes, digital or other images may be used to assist with my care and treatment and will not be released outside of COPCP without written authorization from me or my legal representative.

If these photographs/images are to be taken for any purpose other than care and treatment, the purpose(s) must be stated here:

_____
_____
_____

**Revocation of Consent:** I understand that I may revoke this authorization, in writing, at any time and will not hold COPCP liable for the release of photographs/images that occurred prior to this revocation. Revocation must be made in writing and submitted to the COPC Health Information Department, 655 Africa Road, Westerville, Ohio 43082.

Patient's Name (Print in Full): _____

Signature of Patient or Legal Representative: _____ Date: _____

If Legal Representative has signed on behalf of Patient, state the authority of the Legal Representative to do so: _____
(such as parent of a minor, court-appointed guardian, court appointed Power of Attorney for HealthCare)

Signature of Witness:_____ Position at COPC:_____