dr.taylor

NEUROPSYCHOLOGY

Informed Consent to Photograph

Date: ______________________________

I,_________________________________, due hereby give my consent for Shannon E. Taylor, PhD and the staff members of Dr. Taylor's office to take photograph(s) of _______________________________.

I understand that the photograph(s) will be used for identification purposes only and contained within the confidential file of my child.

Print Name: ____

Signature:____

Relation to Patient: _____________________________________