

dr. taylor

NEUROPSYCHOLOGY

Informed Consent To Photograph - Adult

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 myself.

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

Print Name: _____

Signature: _____