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PHOTO CONSENT AND RELEASE FORM

I, the undersigned, do hereby agree to the following. I am allowing Conroe Family Doctor providers and staff to take photos of my treatment and/or treated areas to be used for the purpose of monitoring my progress, education and or/advertising.

At my request, my identity will remain anonymous. __________ (please initial)

Print Name: ____ Date: _______________________

Signature: ____

Witness: ____ Date: _______________________