South Texas Healthcare
Jibrail Kasperkhan MD
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Photographic Consent Form

Patient Name:_____ **DOB:**_____

By signing below, I give consent to allow Dr. Kasperkhan office to take photographs of myselt and I grant permission for these images to be added to my patient profile. I give consent to Dr. Kapserkhan office to capture images of my wound, lesions, moles, scars, etc. These images will be used by our office to establish treatment options and will allow our provider to track my progression.

_____
Printed Name of Patient or Personal Representative

_____ _____
Signature of Patient or Personal Representative **Date**