

## *Consent to Photograph, Record, And Communication with Insurance Company*

**Project:** Office, Chart, and/or Insurance Co. **Date:** \_\_\_\_\_

**Name of person to be photographed or recorded:** \_\_\_\_\_

**Relationship to the Vein Clinic of South Texas – Victoria &/or Corpus Christi; Robert H. Johnston Jr., MD, :** Patient

The undersigned does hereby authorize the Vein Clinic of South Texas – Victoria &/or Corpus Christi and/or the attending physicians or their designees to: Take and reproduce photographs, and/or slides of the above-named person in connection with the diagnosis, care and treatment, including surgical procedures, or functional capacity of the above named facility. Use of such materials and the person's name is also authorized for use in dealing with the named person's insurance company, including filing claims, medical necessity and appeals with said insurance company.

\_\_\_\_\_ *Initial to indicate you have read, do understand, and approve authorization as stated above*

**Limitations, if any:** \_\_\_\_\_

I release the Vein Clinic of South Texas – Victoria &/or Corpus Christi and its physicians, employees and consultants from any liability in connection with the use of such materials. I understand that this authorization will remain effective unless revoked in writing.

\_\_\_\_\_  
*Signature of Patient*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Time*

\_\_\_\_\_  
*Telephone: Area Code and Number*

\_\_\_\_\_  
*Street Address*

\_\_\_\_\_  
*City/State*

\_\_\_\_\_  
*Zip Code*

\_\_\_\_\_  
*Signature or Parent or Legal Guardian (if patient is under 18)*

\_\_\_\_\_  
*Witness' Signature*

\_\_\_\_\_  
*Date*