Otakar Sroubek, MD, FACC
Marc L. Tenzer, MD, FACC, FACP
Raymond Fisher, MD, FACC

INFORMED CONSENT TO TAKE & UTILIZE PHOTOGRAPHS

I consent to the taking of my photograph or photographs of any part of my body to be used by the physicians of ***North Shore Vein Centre*** for the following purpose(s):

- Monitoring of my personal clinical progress
- Education of physicians, nurses, or other health care personnel
- To obtain approval from insurance company for surgical procedures.
- I grant this as a voluntary contribution.

☐I do ☐/ do not consent to the use of my name in connection with any and all photographs taken of me pursuant to this consent.

______________________________ DOB: ______________
Patient Name (Please print)

______________________________ Date: ______________
Patient Signature

____
Witness Name (Please print)

______________________________ Date: ______________
Witness Signature

Approved:

____
(Physician Signature)

7447 W. Talcott Ave. ♦ Suite# 200 ♦ Chicago, IL 60631-3746