



Consent for Taking, Publication, or Use of Photographs

Patient or Subject: _____

Place: _____

*I hereby authorize _____ (**Institution Name**) to photograph me in connection with my presence in this medical/educational/research facility owned or operated by _____. I give my consent that these photographs may be viewed by others to promote my own health and well-being and the spirit of neuroscience nursing. Also, the photographs may be published and republished, either separately or in connection with each other, in materials developed by the American Association of Neuroscience Nurses.*

I prefer not to be identified by full (first and last) name.

Date _____

Signature _____

Consent on behalf of a minor: [I] [we] certify that [I am] [we are] the parent[s] or person[s] legally appointed the guardian[s] of the above signatory of this instrument, a minor person, and that [I] [we] also hereby give the consents and make the authorization of this instrument herein above contained.

I prefer the minor not to be identified by full (first and last) name.

Date _____

Signature(s) _____
(Minor)

(Parent or Guardian)