VEREEN
REHABILITATION CENTER

**Wound Care Authorization of Image Use**

I authorize the Vereen Center and Colquitt Regional Medical Center to photograph and/or video my treatment in the Wound Care Clinic.

Details of Treatment: _____

_____

I agree that the Vereen Center may use any images or videos for educational purposes such as cases studies and in-services. I understand that my identity will be protected and not revealed in any manner.

I relieve the Vereen Center, Colquitt Regional Medical Center, and its employees from any and all liability arising from this recording of my image.

This authorization will remain in effect for any and all images and/or videos recorded during my care at the Vereen Center Wound Care Clinic unless otherwise indicated by the patient or caretaker.

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian Signature (if applicable) Relationship to Patient

_____

Witness/Health Care Provider Signature