**Mercy Clinic**
**Autism Diagnostic Clinic**
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# CONSENT AND REALEASE OF LIABILITY FOR PHOTOGRAPY BY MERCY HEALTH CENTER PERSONNEL

We routinely take photographs of the children and adolescents we see to keep in their file for reference/identification. This information is kept confidential along with their medical record. By signing this form as a parent or guardian you are agreeing to allow us to photograph your child. This form has been explained to me and I certify that I understand its contents and on behalf of

_____ _____
Patient's Name Date of Birth

I consent to the above described photographing of my child and understand that any photograph taken will be kept confidential as part of their medical record.

_____ _____
Signature of parent or guardian Date