


Photo Consent

Patient Name	:	Vision Test Patient			Emirates ID	:	784-6987-5266587-7	
File No	:	2	DOB	:	2020-06-17	Nationality	:	Indian
Gender	:	Female	Doctor's Name	:	Doctor Vision	Date	:	2023-11-27

I Vision Test Patient hereby acknowledge that I have been advised that photographs will be taken before and after the procedure. The photographs will be taken by one of the members of the VISION MEDICAL & DENTAL CENTER (Abu Dhabi) medical staff. Any photographs taken will become part of my medical records and any necessary medical treatment.

Sign here, only if all of your questions have been answered to your satisfaction	
PATIENT	DOCTOR
	<div style="border: 1px solid black; width: 100px; height: 80px; margin: 0 auto;"></div>
Patient Name Vision Test Patient Date 2023-11-27	Doctor - Laser (DHA101) 2023-11-27