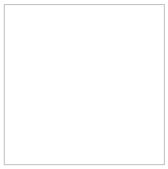
Photo Consent

Patient Name	:	sai krishna				Emirates ID	:	784-8666-6666666-7
File No	:	8	DOB	:	1996-09-25	Nationality	:	Other
Gender	:	Male	Doctor's Name	:	test test	Date	:	2024-04-11

I sai krishna 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
	
Patient Name sai krishna Date 2024-04-11	test test - Laser (1) 2024-04-11