# Photo Consent

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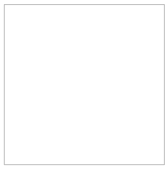
|---|---|---|---|---|---|---|---|
| Patient Name | : | Vision Test Patient | | | | Emirates ID | : | 784-6987-5266587-7 |
| File No | : | 2 | DOB | : | 2020-06-17 | Nationality | : | Indian |
| Gender | : | Female | Doctor's Name | : | Doctor Vision | Date | : | 2023-11-25 |

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 |
|  |  |
| Patient Name<br>Vision Test Patient<br><br>Date<br>2023-11-25 | Doctor - Laser (DHA101)<br>2023-11-25 |