

Photograph/Media Consent And Release

Patient Name	:	Reshma Siya	Emirates ID	:	784-6478-3648736-8
File No	:	4	DOB	:	1995-05-21
Gender	:	Female	Doctor's Name	:	dermatology derma
			Date	:	2024-03-02


I hereby consent and authorize **AUSTRALIA MEDICAL CENTRE** to take photographs or motion pictures of me; or to produce videotapes, audiotapes, closed circuit television programs, web casts, or other types of media productions that capture my name, voice, and/or image (any of the foregoing types of media are called the "Materials" in this Consent and Release form).

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I represent that I am at least 18 years of age, or if not, that I have secured the signature of my parent or legal guardian.

Sign here, only if all of your questions have been answered to your satisfaction		
Patient	witness	Doctor
		
Patient Name Reshma Siya Date 2024-03-02	Witness Name erewr Date 2024-03-02	Doctor's Name dermatology derma Date 2024-03-02