Shaker Place Rehabilitation and Nursing Center

Photography Consent

I____ understand that a facial photograph will be taken to use as identification. Additionally, photographs of specific conditions or injuries may be taken to supplement the medical record.

I do hereby give authorization and consent to the Shaker Place Rehabilitation and Nursing Center (herein referred to as Shaker Place) to photograph for the purposes of Shaker Place's activity or socialization programs and consent to the publication of said photograph (s) in newsletters, the newspaper, brochures for use on television, and for other marketing purposes as may be determined by Shaker Place. _________ (initials)

____

Signature

____

Date

____

Signature of Legal Representative

____

Relationship

____

Witness

*****UPON COMPLETION, THIS FORM IS TO BE GIVEN TO THE ACTIVITIES DIRECTOR*****

Revised 2/19