PROVIDENCE
Health & Services
Providence Holy Cross Medical Center
Providence Saint Joseph Medical Center
Providence Tarzana Medical Center

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North Hollywood, CA 91605
T: 818-847-3860
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Tattoo Removal Program

CONSENT FOR PHOTOGRAPH

Name: _____

Date of Birth: _____

Permission is granted to the Tattoo Removal Program, any and all of its representatives or agents on its behalf, to photograph and/or videotape in relation to the Tattoo Removal Program and its community service component for purpose of client's comparison for different phases of the tattoo removal process and for our patient records. The photographs are discharged and released from any and all claims arising out of the photos or videotape or any rights I may have to photograph or tape.

I have read the statement and grant my permission for photography or videotaping.

Signature **Date**