Photo Acknowledgment

I understand that my pictures are taken before and after my procedures as a routine part of the services I receive with Dr. Wendy Dickerson, NMD. I acknowledge that the pictures taken are for the purposes of my confidential medical file only, and will NOT be used for any purposes other than for providing me the best possible patient care. I understand that only I can request any copies of these pictures that may be released from Dr. Wendy Dickerson, NMD and that to do so my request must be provided in writing.

Name:_____ Date:_____

Signature:_____

Witness:_____ Date:_____