Barbra McDowell, Ph.D.
Professional Psychology Group, Inc.

Pediatric Neuropsychology
Clinical Psychologist
PSY 15622

CONSENT TO PHOTOGRAPH

I, _____, parent or legal guardian, hereby authorize Professional Psychology Group, Inc. to take a picture of my dependent, minor child, _____. The picture will be used solely for purposes of identification by personnel at Professional Psychology Group. I understand that the picture will be placed in my child's file, but will not be part of his or her official medical record. The picture will not be reproduced or otherwise released to any person or organization without my written permission, and I understand I have the right at any time to revoke this consent and to ask that the picture be returned or destroyed. I also understand that the services received by my child will in no way be affected by whether I consent to having the picture taken.

_____ _____
Patient Signature (>12 years of age) Date

_____ _____
Parent/Legal Guardian Date

_____ _____
Witness Date

29863 Santa Margarita Parkway Suite 105, Rancho Santa Margarita, CA 92688
phone 949-713-3188 / fax 949-713-3189
BMcDowell@ProfessionalPsychologyGroup.com / www.ProfessionalPsychologyGroup.com