



**PHOTO RELEASE FORM**

**START Midwest  
5800 Foremost Drive SE, Suite 100  
Grand Rapids, MI 45546**

**TELEPHONE NUMBER(S), DAYTIME: (616) 954-5554  
AFTER HOURS: (616) 954-5554**

You are being asked to give permission for clinic personnel to take photographs of you at any given time once you come to our facility. Photographs may be taken for the following reasons:

- For patient identification purposes
- To monitor any visible reactions you might have once you start receiving treatment
- To note any visible lesions you might have before receiving treatment
- To track any changes in your visible lesions

Unless required by a specific research protocol, we will not share your photographs with anyone (such as study sponsors if you are participating in a specific study) unless it is deemed necessary to discuss your treatment options.

Your pictures may be used in scientific publications.

Your pictures may also be edited.

Your name will not be on the pictures. Instead, we will use your initials and medical record number. You have the right to cancel this Photo Release Form.

**Statement of Consent:**

I have read this release and understand its meaning. I understand I do not need to sign this Photo Release Form in order to receive treatment at START Midwest.

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Printed Name of Adult Study Subject

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Signature of Adult Study Subject

Date

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Printed Name of Person Explaining Release Form

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Signature of Person Explaining Release Form

Date

You will be given a copy of this release form to keep.