Mental Health Partners
Roberto Hernando MD PA
8200 SW 117th Avenue
Suite 202
Miami, Florida 33183
Ph: (305) 274 9206 F: (305) 274 9254

Consent for Photography

This is to certify that I, _____, give my permission to photograph me during my office visit as a patient at Mental Health Partners, Dr. Roberto Hernando's MD Office. I hereby release the office, its employees, physicians from any legal situation that may arrive from the above. Further, I understand this photograph will become a permanent part of medical record and will be used for identification purposes.

Patient Signature (Guardian): _____ Date: _____

Consentimiento para ser Fotografiado (a)

Yo: _____, doy permiso para ser fotografiado durante mi visita a la ofificna del Dr. Roberto Hernando. Yo salvo de responsabilidad a la oficina, sus medicos y empleados. Yo acepto que esta foto va a ser parte permanente del record clinic y sera utilizada para propositos de identificacion.

Firma del Paciente (Guardian):_____ Date :_____