

# *Northern Lights Surgical Associates, P.C.*

*Sarah C. Troxel, M.D.*

*Phone: 907-562-6886*

*3340 Providence Drive, Suite 363*

*FAX: 907-562-1021*

*Anchorage, Alaska 99508*

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## **CONSENT TO PHOTOGRAPH**

The undersigned do hereby authorize Dr. Sarah C. Troxel, M.D. to photograph or permit other persons (staff members) to photograph \_\_\_\_\_ while

*Please Print Patient Name*

under the care of Dr. Sarah C. Troxel, M.D. and agree that they may use or permit other persons to use the negatives or prints prepared therefrom for such purposes and in such manner as may be deemed necessary.

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient Printed Name**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Office Staff Witness**

\_\_\_\_\_  
**Date**