Consent for Medical Photography

Patient Name: _____ Date: _____

___ Check here if patient is a minor or unable to give consent

By signing this document I confirm that this consent form has been explained to me in terms that I understand.

1. I consent for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications. I understand that the image maybe seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible for someone to recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record. If the photographs are of my face, my eyes will be blocked out to protect my identity.

_____(Signature _____(Witness)

2. I agree for my image to be shown for teaching purposes **and** to be used for my medical record **but not for** for medical publication.

_____(Signature _____(Witness)

3. I agree to use of my image for medical records **ONLY:**

_____(Signature _____(Witness)

For patients between 7 and 18 a signature below indicates that the information in this consent form has been explained to me, and I assent to use my image as outlined above:

_____(Signature _____(Witness)