Patient name: …….. Date: ……

☐ Check here if minor or unable to provide consent

I consent for medical photographs and/or videos to be made of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medicals textbooks or journals as I have designated below. By consenting to these medical photographs and/or videos I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may contact:

By signing this form below I confirm that this consent form has been explained to me in term which I understand

1) I consent for these photographs and/or videos to be used in medical publications, Including medical journals, textbooks, and electronic publications. I understand that the image and/or videos may be seem 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 and/or videos will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image and/or videos to be shown for teaching purposes and to be used for my medical record.

---------- (signature) ---------- (witness)

2) I agree for my image and/or videos to be shown for teaching purposes AND to be used for my medical record but NOT FOR medical publication:

---------- (signature) ---------- (witness)

3) I agree to use of my image and/or videos for medical records ONLY:

---------- (signature) ---------- (witness)

For patients between ages 7 and 18 years, a signature below indicates that the information in this consent form has been explained to me, and I assent to use of my images and/or videos as outline above:

---------- (signature) ---------- (witness)