Informed Consent
Publication of Patient Photographs

Date:

Patient:

Date of Birth:

Purpose of Consent:
I consent for medical photographs and/or video images to be taken of me by Dr. _____/Practice Name. I understand that these images may be used for the following purposes (please initial each that applies):

- ◯ For inclusion in my medical record.
- ◯ Medical teaching or training (educational purposes).
- ◯ Publication in medical journals, textbooks, or electronic/online publications.
- ◯ Marketing and advertising purposes (website, print, digital, or social media).

Conditions of Use:

- ◯ I understand that I will not receive any payment or royalties for the use of these images.
- ◯ I understand that, although identifying information such as my name will not be used, it is possible that someone may recognize me from the images.
- ◯ I understand that once published, images may be distributed worldwide, especially through electronic media, and cannot be removed from print publications, though reasonable efforts will be made to remove images from online platforms if I withdraw consent in the future.
- ◯ I understand that refusal to consent to photography, or withdrawal of consent, will not affect the medical care I receive.
- ◯ I may withdraw my consent at any time by contacting Dr. _____/Practice Contact Information. (Note: Images already published in print cannot be retracted, but future use will cease upon withdrawal of consent).
- ◯ I have had the opportunity to ask questions about this consent and all my questions have been answered to my satisfaction.

Authorization and Release:
By signing below, I confirm that this consent form has been explained to me in terms I understand. I authorize Dr. _____/Practice Name to use the photographs and/or video images as indicated above.

Patient Signature:_____

Witness Signature:_____

If you have any questions or wish to withdraw your consent in the future, please contact: _____