

CONSENT FOR MEDICAL PHOTOGRAPHY

Purpose: For medical records, consultation, teaching, and publication

I understand that photographs, videotaping, and other digital recordings may be made and recorded of me. I understand the term "medical images" as used here includes electronic as well as printed images. I understand and agree that the nature of use of these images is for purposes of medical records, consultation, teaching, and publication. Although measures will be taken to reduce or eliminate identifying features, the possibility remains that someone may recognize me.

The use of medical images for medical records includes recording and saving images in the print and or digital records for office use. The use of medical images for consultation purposes includes sharing of these images with other healthcare providers who are involved in the diagnosis and treatment of my conditions. The use of medical images for teaching purposes includes the use of my images for teaching medical students, medical residents, practicing physicians and other healthcare professionals. The use of medical images for publication includes my images or recordings in print or online medical journal publications. I understand that if I allow my images be used in publications, I have the right to revoke this consent up until the time the images are accepted for publication. Once the images have been published, I may not revoke my consent. Anonymity cannot be guaranteed in publications.

I have been provided the opportunity to ask questions concerning medical photography and understand that refusal to consent will not affect my medical care. If the patient is under 18 years of age, I verify that I am the parent or guardian of patient _____, and that I will sign for the patient.

_____ I consent to allow medical photographs for **all purposes** described above.

_____ I consent to allow medical photographs for **only** purposes that I have checked below.

_____ Medical records	_____ Consultation
_____ Teaching purposes	_____ Publication

_____ I do not provide consent to allow recording or saving of medical photographs.

Date _____ Time _____

Place: _____ Dermatology Clinic -- Ocean Springs office
_____ Dermatology Clinic – Cedar Lake office

Signature of patient: _____ (Guardian/relative)

Witness: _____ Physician/PA Signature: _____