

Consent for taking and publishing photographs

Name of patient in English (BLOCK LETTERS)

Place Date

To be read and signed by the patient in the presence of a witness:

In connection with the medical services that I am receiving from my physician, Dr. ,

I consent that photographs may be taken of me or of parts of my body and published under the following conditions:

- 1) The photographs may be taken only with the consent of my physician and under such conditions and at such times as may be approved by my physician.
- 2) The photographs shall be taken by my physician or by a photographer approved by my physician.
- 3) The photographs shall be used for medical records and if in the judgement of my physician, medical research, education, or science will be benefited by their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical book, or used for any other purposes that my physician may deem proper in the interest of medical education, knowledge, or research; provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name.
- 4) The aforementioned photographs may be modified or retouched in any way that my physician, at his or her discretion, may consider appropriate.

Signature of patients Date signed

Signature of witness Date signed

Signature of physician Date signed