Consent for taking and publishing photographs of minors

Name of patient in English (BLOCK LETTERS)

Place ..... *Date* .....

To be read and signed by both parents / surviving parent of the patient (if younger than 18 years) in the presence of a witness:

In connection with the medical services that are being rendered by Dr. .....

to the above-named patient, I/we consent that photographs may be taken of the said patient or of parts of his or her body and published under the following conditions:

1) The photographs may be taken only with the consent of the above-named physician and under such conditions and at such times as may be approved by him or her.
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 the above-named physician, medical research, education, or science will be benefited by their use, such photographs and information relating to this case regarding the above-named patient may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purposes that the above-named 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 the patient shall not be identified by name.
4) The aforementioned photographs may be modified or retouched in any way that the above-named physician, at his or her discretion, may consider appropriate.

I/We warrant by my/our signature(s) below that we are the parents / I am the surviving parent (delete as applicable) of the above-named patient, and that he or she is years of age.

Name of patient's father (BLOCK LETTERS) *Signature of father*

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Name of patient's mother (BLOCK LETTERS) *Signature of mather*

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Signature of witness *Date signed*

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Signature of physician *Date signed*

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