Metro Infectious Disease Consultants,

Patient Consent for Medical Photography

Patient Name: _____ Date: _____

I consent for medical photographs 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 medical records, for purposes of medical teaching, or for publication in medical photographs 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 terms which I understand.

CHOOSE ONE OPTION

1. I consent for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications. I understand that the image may be seen 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 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 to be shown for teaching purposes to be used for my medical record.

_____ _____

(Signature) (Witness/Provider)

2. I agree for my image to be shown for teaching purposes **AND** to be used for my medical record but **NOT FOR** medical publication:

_____ _____

(Signature) (Witness/Provider)

3. I agree to use of my image for medical records **ONLY**:

_____ _____

(Signature) (Witness/Provider)

4. I agree for my image to be shown for illustration purposes in the office for patient education and my medical record but NOT FOR medical publication.

_____ _____

(Signature) (Witness/Provider)

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 as outlined above:

_____ _____

(Signature of patient) (Witness/Provider)