Patient Consent for Medical Photography

Patient name: Date:

☐ check here if minor or unable to provide consent

I consent for medical photographs to be taken of me, or my child (or person for whom I am legal guardian) by …….. or a representative.

I understand that the information may be used in my medical record, for purposes of medical teaching, or for public publication in medical textbooks or journals. By consenting to these medical photographs I understand that I will not receive payment from any party. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. Refusal to consent to photographs will in no way affect the medical care I will receive.

I authorize the use of these images:

YES / NO For the purpose of writing a thesis or student paper

YES / NO For purposes of medical teaching

YES / NO For public publication in medical textbooks or journals

By signing this form below I confirm that this consent form has been explained to me in terms, which I understand.

I represent that I am the parent/guardian of

……

(Patient name)

……	……
(Print name)	(Print name)
……	……
(Date)	(Date)
(Signature)	(Signature)