

### **Patient Consent for Medical Photography**

Patient Name (PRINTED): \_\_\_\_\_ Date: \_\_\_\_\_

Check here if minor or unable to provide consent

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 record, for purposes of medical teaching, or for publication in medical textbooks or journals as I have designated below. By consenting to these 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 Kenner Dermatology Center.

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

1. I consent for these photographs to be used in medical publications, including medical journals, textbooks and electronic publications. I understand that the material will be published without my name attached. Every effort will be made to ensure I cannot be identified, but my complete anonymity cannot be guaranteed. The material will not be used out of context, e.g. for advertising or packaging other products. I also agree for my image to be shown for teaching purposes and to be used for my medical record:

\_\_\_\_\_ (Signature)

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)

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

\_\_\_\_\_ (Signature)

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/Guardian)