PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

Patient Name: ______________________________ Date: ____________________

I consent for medical imaging (photo, video, and/or audio) to be made of me or my child (or for person whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching at Excel Neuro-Optometric Clinic, or for publication in medical textbooks or journals as I have designated below. By consenting to this medical photography, I understand that I will not receive payment from any party. Refusal to consent to photographs, video, and/or audio recording 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 the staff at Excel Neuro-Optometric Clinic.

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

PICK AND SIGN ONE OPTION ONLY

□ 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 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 at Excel Neuro-Optometric Clinic and to be used in my medical record.

Patient Signature: ___________________________ Date: ______________

□ Option 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.

Patient Signature ___________________________ Date______________

□ Option 3

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

Patient Signature___________________________ Date______________