Patient Consent for Medical Photography

Purpose: for medical records, consultation, teaching, and publication

I understand that photographs, in both electronic and/or print format, may be recorded of me to document a medical condition, help with the diagnosis and/or treatment of a condition, and/or help plan details for surgery. I understand and agree that the nature of use of these images is for the purposes of medical records, consultation, teaching, and/or publication. Although measures will be taken to reduce or eliminate identifying features, the possibility remains that someone may recognize me. Images that identify me will be released and/or used outside the office only upon written authorization from me or my legal representative.

I understand that these images will be securely stored for the period required by law or as outlined by our Privacy Policies. Gawley Plastic Surgery, MD Skin Lounge and/or North Scottsdale Outpatient Surgery Center will retain all ownership rights to the images, but I will be allowed to view them or obtain copies.

The use of medical images for medical records includes recording and saving images in the print and/or digital records for office use. The use of medical images for consultation purposes includes sharing of these images with other healthcare providers who are involved in the diagnosis and treatment of my conditions. The use of medical images for teaching purposes includes the use of my images for teaching medical students, medical residents, practicing physicians and other healthcare professionals. The use of medical images for publication includes my images or recordings in print or online medical journal publications. I understand that if I allow my images to be used in publications, I have the right to revoke this consent up until the time the images are accepted for publication. Once the images have been published, I may not revoke my consent. Anonymity cannot be guaranteed in publications.

I have been provided the opportunity to ask questions concerning medical photography and understand that refusal to consent will not affect my medical care. If the patient is under 18 years of age, I verify that I am the parent or guardian of patient ____________________________, and that I will sign for the patient.

☐ I consent to allow medical photographs for all purposes described above.

☐ I consent to all medical photographs for only purposes that I have checked below:
  ☐ Medical records
  ☐ Consultation
  ☐ Teaching Purposes
  ☐ Medical Publication

Patient Name / Signature: __________________________________________ Date: __________

(Or) Parent/Guardian Signature: __________________________________________ Date: __________