



Name \_\_\_\_\_

Date \_\_\_\_\_

### **Authorization to Release Medical Photographs, Slides and/or Video Tapes**

\_\_\_\_\_ I hereby authorize \_\_\_\_\_, M.D., and/or his/her associates or licensees to take and use photographs, slides and/or video tapes for professional medical purposes deemed appropriate including but not limited to showing the photos, slides and/or videotapes on public, commercial and other electronic media including practice website, or using the photographs, slides and/or videotapes for purposes of medical publication, lay publication, medical and patient education or during lectures to medical or lay groups.

\_\_\_\_\_ I understand that I will not be entitled to any payment or other form of remuneration as a result of any use of the photographs, slides and/or videotapes of me.

\_\_\_\_\_ I decline to have my image or likeness used in any of the above formats or publications.

\_\_\_\_\_

(Patient or Legal Guardian Signature)

\_\_\_\_\_

(Date)

\_\_\_\_\_

(Witness Signature)

\_\_\_\_\_

(Date)

\_\_\_\_\_

(Doctors Signature)

\_\_\_\_\_

(Date)