

**AUTHORIZATION FOR AND RELEASE OF
MEDICAL PHOTOGRAPHS**

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Patient Name:

Date:

INTRODUCTION

Medical photographs may be taken before, during, or after a surgical procedure or treatment. Consent is required to take such images.

Additionally, patients may consent to release this medical photography for a stated purpose.

1. CONSENT TO TAKE PHOTOGRAPHS

I hereby authorize W. John Bull, Jr., M.D. and or his/her associates or licensees to take pre-operative, intra-operative, and post-operative photographs.

2. CONSENT FOR RELEASE OF PHOTOGRAPHS

I hereby authorize W. John Bull, Jr., M.D. and or his/her associates or licensees to use pre-operative, intra-operative, and post-operative photographs for professional medical purposes deemed appropriate including but not limited to showing these images for purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and /or my interview.

Date:.....

Patient Signature:.....

Witness:.....