Tri-Valley Orthopedic Specialists, Inc.

Solving Musculoskeletal Problems Since 1985

PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

Patient Name: _____ Acct #_____ 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 Tri-Valley Orthopedic Specialists, 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 Tri-Valley Orthopedic Specialists.

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 image may be seen by members of the general 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 Tri-Valley Orthopedic Specialists and to be used in my medical record.

Patient Signature _____ Date_____

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_____

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

Patient Signature _____ Date_____