Patient Consent for Medical Photography

Patient Name: ________________________________________ Date: __________________

☐ Check here if minor or unable to provide consent.

I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian).

I understand that the information may be used in my medical record, for purpose of medical teaching, or
the publication in medical textbooks or journal as I have designated below. By consenting to these medical
photographs I understand that I will not receive payment from any party. Refusal to consent to photographs
will in no way affect the medical care I will receive. However, the tracking of patient progress may be inhibited.
If I have any questions or wish to withdraw my consent in the future I may contact:

Summerlin Dermatology
Attention: Administrator
Call 702.243.4501
or e-mail: info@summerlinderm.com

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

☐ 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 scientist 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 and to be used for my medical record.

Patient Signature: __________________ witness: __________________

☐ 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: __________________ witness: __________________

☐ I DO NOT consent to any of the above (medical records only):

Patient Signature: __________________ witness: __________________

For patients between ages 7 and 18 years, a signature below indicates that the information in this consent form
has been explained to me, and I assent to use of my images as outlined above:

Patient Signature or Legal Guardian: _________________________ Date: _______________