Medical Illustration Release Form

Patient Name

Date of Birth

Contact Email or Phone

Address

I hereby authorize the use of medical images, illustrations, photographs, or video recordings taken of me for educational, academic, or professional publication purposes. I understand that my identity will be protected as much as possible and that no personal information will be disclosed without my consent.

Patient/Guardian Signature

Date

Witness

Date

If patient is under 18 years of age, this form must be signed by a parent or legal guardian.