Medical Case Report Image Release

I hereby consent to the use of medical images, photographs, and/or videos depicting myself (or my child/ward) for the purpose of publication in a medical journal, presentation, or educational material.

Patient Information

Patient Name

Date of Birth

Medical Record Number

Representative (if applicable)

Name of Representative

Relationship to Patient

Description

Description of image(s)/material to be released

☐ I understand that my name will **not** be published and efforts will be made to conceal my identity, but complete anonymity cannot be guaranteed.

Signature

Signature

Date