Surgical Procedure Image Use Consent

I hereby authorize the use of images or photographs of myself taken before, during, and after my surgical procedure for the purposes of education, publication, medical records, or presentations. I understand that my identity will be protected as much as possible, and that no identifying information will be included.

Purpose of Image Use

- Medical education and training
- Scientific publication or presentations
- Medical records documentation
- Other professional uses

I acknowledge that these images may be used in various media, including print, electronic, and online formats. I understand that my consent is voluntary and that I may withdraw it at any time by notifying my surgical provider in writing.

Patient Information

Patient Name:

Date of Birth:

Surgical Procedure:

Date:

Patient Signature:

Witness Name:

Witness Signature:

Date: