Maxillo*facial*

Medical Photography Consent Form

Patient Name: _____
Date of Birth: _____

I, _____, hereby provide authorization to my medical team to photograph or videotape me for medical, scientific, or educational purposes. I understand that these photographs or videos may include identifiable images of me and may be used in the following ways:

1. **Educational Purposes:** The photographs or videos may be used for educational purposes, including but not limited to medical lectures, presentations, publications, and online educational platforms including www.maxillofacial.org.

2. **Research:** The photographs or videos may be used for research purposes, including medical research studies, publications, and presentations.

3. **Internet Posting:** I understand that the photographs or videos may be posted on the internet for educational purposes. This may include posting on professional medical websites, educational platforms, social media, or other online channels.

I understand that my identity may be revealed in these photographs or videos, and I hereby consent to such use. I understand that my personal health information will be kept confidential in accordance with applicable laws and regulations.

I understand that I will not receive any compensation for the use of these photographs or videos.

I have had the opportunity to ask questions about the use of these photographs or videos, and all my questions have been answered to my satisfaction.

I hereby release and discharge maxillofacial.org, their associates, employees, and any other person or entity involved in the creation or publication of these photographs or videos, from any and all claims, liabilities, or damages arising out of or relating to the use of these photographs or videos.

This consent is effective from the date signed below and shall remain in effect indefinitely unless revoked in writing.

Patient Signature: _____

Date: _____