UNIVERSITY OF SOUTH CAROLINA
SCHOOL OF MEDICINE
UNIVERSITY SPECIALTY CLINICS®

CONSENT FOR PHOTOGRAPHY

As part of our overall evaluation of our patients we frequently prefer to obtain preoperative and postoperative photographs. These are used both for the medical record documentation purposes and for educational purposes for doctors in training. With our consent, these photographs may be used in medical journals, textbooks, and slide presentations to other physicians and community educational programs.

I, _____, hereby consent to all photographs of my body or parts of my body to be taken as the doctor sees fit. They may be used for the above-described purposes. I further understand that for a small processing fee, copies may be made available to me.

PATIENT SIGNATURE: _____ **DATE:** _____

If the patient is a minor, or cannot sign for his or herself, please fill out below.

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO PATIENT: _____

WITNESS: _____ **DATE:** _____

DEPARTMENT OF SURGERY
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