CHARLES WONG D.O.

HAND SURGERY

# PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

By signing below I, _____, consent to having photographs
( print name )
and / or video recordings performed for the purposes of being a part of the medical record, teaching, and for use in medical publications, including medical journals, textbooks, and electronic publications. I understand that the images may be seen by members of the general public, in addition to scientists and medical researchers who regularly use these publications in their professional education. Although these images will be used without identifying information such as my name, I understand that it is possible that someone may recognize me.

(PLEASE ONLY CHOOSE ONE)

1- I consent for my images to be used in medical publications as enumerated above, as well as for teaching purposes, and as a part of my medical record.

Signature: _____

Date: _____

2- I consent for my images to be shown for teaching purposes AND for use in my medical record. I DO NOT consent for my images to be used in medical publications.

Signature: _____

Date: _____

3- I agree to the use of my images for the medical record ONLY.

Signature: _____

Date: _____

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