AUTHORIZATION FOR AND RELEASE OF MEDICAL PHOTOGRAPHS/SLIDES/AND/OR VIDEOTAPES

INSTRUCTIONS

This is a consent document that has been prepared to help inform you concerning permission to take photographs/slides, and to use these images for a purpose as defined within this consent document.

It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by Dr. Taylor.

INTRODUCTION

When you have decided to proceed with surgery, it will be necessary to take photographs to document your anatomy "Before" surgery. This helps both Dr. Taylor and the patient prepare for surgery during pre-op discussions. Photos are often taken in the OR to document tissue removal or if there is an unusual or interesting finding. After surgery, "After" photographs are again taken to compare with the "Before" photos. It is difficult to remember precisely your own pre-op anatomy, thus the photos serve as a reminder of your pre-op condition. Your consent is required to take such images.

Additionally, patients may consent to release these medical photographs/slides for a stated purpose.

1. CONSENT TO TAKE PHOTOGRAPHS/SLIDES

I hereby authorize Anne Taylor, M.D. and her associates or licensees to take pre-operative, intra-operative, and post-operative photograph/slides for this procedure and all subsequent office visits and procedures.

2. CONSENT FOR RELEASE OF PHOTOGRAPHES AND SLIDES

I hereby authorize Anne Taylor, M.D. and her associates or licensees to use pre-operative, intra-operative, and post-operative photographs/slides for professional medical purpose deemed appropriate including but not limited to showing these images on public or commercial television, electronic digital networks, for purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and/or my interview.

I authorize Anne Taylor, M.D. to print my photos and send to my designated address after my final follow up visit.

I authorize Anne Taylor, M.D. to print my photos and send to my designated physician as stated. Yes _______ No _______ Doctor's Name ___________________________________

Doctor's Address ____

*SIGNATURE:*____

*DATE:*________________________________

5/06 Version