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CONSENT FOR PHOTOGRAPHY

Facility: _____________________________ Patient: _________________________

Date: ________________ Physician: _____________________________________

In connection with the medical care that I am receiving through this facility, I consent that still or digital photographs may be taken of wound areas on my body, under the following conditions: for the purpose of medical documentation, education, knowledge, research, and/or media publicity, which Advantage Surgical Wound Care may deem proper.

I understand that neither myself/the patient nor members of my/the patient's family will be identified by name in connection with any public use of this material, nor any other identifying material be connected to these photographs that could be construed as a violation of my privacy.

I grant this consent as a voluntary contribution and I waive any and all rights I/patient may have to royalties or other compensation in connection with any such use. I confirm that I have read and fully understand the above prior to signing.

The photographs will be taken by a member of the nursing staff at ______________________________ (institution/agency), or by a designated photographer. I accept no compensation or other remuneration for the use of such photographs as I have authorized.

Signed: ____ Date: _________________

Or authorized signer: _______________________________________ Date: _________________

Reason patient cannot sign: _________________________________

Witness:

*If subject is a minor, consent must be obtained from parents

Clinician Signature: _______________________________________ Date: _________________

Printed Clinician Name: ____________________________________