Southwest Virginia ENT & Facial Plastics

Michael Bowman, MD
Ben Hull, MD
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MEDICAL PHOTOGRAPHY & VIDEO CONSENT FORM

In connection with the medical care which I am receiving from Dr. Bowman, Nelson, or Hull, I consent that photographs & or video may be taken of me or parts of my body under the following conditions:

A. The photographs/videos may be taken only with the consent of my physician and under such conditions and at such time as may approved by him or her.

B. The photographs/videos shall be taken by my physician or by a photographer approved by my physician.

C. It is understood that if there is ANY use or publication or reproduction of my photographs/videos outside of my medical record I will never be identified by name.

D. The photographs/videos shall be used for medical records. If my doctor deems that medical research, education, or science will benefit from their use, such photographs/videos and information related to my case may be published and republished, either separately or in connection with each other, in professional journals, books, websites or used for any other purpose that he may deem proper in the interest of medical education, knowledge, or research.

E. If you specifically consent for the use of your photographs/videos (or cropped versions thereof) to be shown to other patients as a part of treatment education, please initial here: ____________

F. If you specifically consent to the use of your photographs/videos (or cropped versions thereof) in material including print, television, social media and/or other internet publication, please initial here __________

Patient's Name/B-day (PRINT): ____

Patient's/Guardian signature ____

Witness____

Date _________/_________/_______ **Phone** (______) _______ - ________