**PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I consent for medical photographs to be made of me (or person for whom I am a legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching, for insurance purposes, or for publication in textbooks, journals, articles, or on the internet. By consenting to these medical photographs I understand that I will not receive payment from any party. Refusal to consent to these medical photographs will in no way affect the medical care I will receive at Midwest Breast & Aesthetic Surgery. If I have any questions or if I wish to withdraw my consent in the future I may contact: info@mwbreast.com or call 855-687-6227.

I understand that the images may be seen by members of the general public, in addition to medical professionals that regularly use these images in their professional education. **Every effort will be made by Midwest Breast & Aesthetic Surgery and its employees to exclude or reduce all identifying entities.** Although these photographs will be used without identifying information, such as my name, I understand that it is possible that someone may recognize me.

By signing this form below I confirm that this consent form has been explained to me in terms which I understand, all of my questions have been answered, and that I assent to use of my images.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_