Patient photographic and videographic consent, authorization and release form

JYMS
JOURNAL OF YEUNGNAM MEDICAL SCIENCE

I am informed and aware of photographs, videotapes and other images (imaging records) taken by Dr. _____ or his designee(s) of myself or any parts of my body regarding surgical procedures carried out by Dr. _____ . I understand and consent that such imaging records may and will be used by Dr. _____ as reference in diagnosing and treating other patients in the future. I further consent to the release and transfer of copyright ownership by Dr. to *Journal of Yeungnam Medical Science* of such imaging records.

I understand that by consenting on release of my imaging records, these may and will be used in upcoming issue or issues of the journal, as well as on the journal website, or any other print or electronic media for the purpose of informing medical professionals or other readers about surgical methods. I understand that when these imaging records are included in any articles, medical information regarding sex, age, operative date and treatment results may and will be included together. But I, nor any member of my family, will be identied by name in any publication, and any information that may aid in identifying me or my family will not be exposed. (In case of facial photographs, the photo is cropped to only necessary parts in order to make individual identication impossible.) I understand that whether I consent on this form or not, it bears no consequences whatsoever on any future actions, and that there will be no eect on the medical treatment I receive from Dr. _____ or any subordinates.

I grant this consent as a voluntary contribution in the interest of public education, and certify that I have read the above Consent, Authorization and Release form and fully understand its terms. I understand that, if I do not revoke this authorization, it will expire ten years from the date written below.

I hereby transfer in above-mentioned terms, the copyright of my imaging records to

Dr. _____ .

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Name: _____ **Signature:** _____

Hospital: _____ **Department:** _____

Designated Doctor: _____ **Signature:** _____