Patient Photographic and Videographic Consent, Authorization and Release Form

I am informed and aware of the 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. ___________________________ for reference in diagnosing and treating other patients in the future. I further consent to the release
and transfer of copyright ownership of such imaging records obtained by Dr. ___________________________ to Archives of Craniofacial
Surgery.

I understand that by consenting to the 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 profes-
sionals 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. However, neither I nor any member of my family will be identified
by name in any publication, and any information that may aid in identifying me or my family will not be exposed. (In case of fa-
cial photographs, the photo is cropped to only necessary parts in order to make individual identification impossible.)

I understand that whether I consent through this form or not, it bears no consequences whatsoever on any future actions, and
that there will be no effect 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 Con-
sent, Authorization and Release form and fully understand its terms.

I understand that, if I do not revoke this authorization, it will expire 10 years from the date written below.

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

Dr. ___________________________.

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Name: ___________________________   Signature: ___________________________

Hospital: ___________________________   Department: ___________________________

Designated Doctor: ___________________________   Signature: ___________________________