Consent to take Photographs/Slides/Videotapes

I hereby authorize Dr. John P. Stratis- Dr. Scott M. Gayner and/or his associates or licensees to take preoperative, intraoperative and post operative photographs, slides and/or videotapes for professional medical purposes as part of the medical record.

Date _____

Print Name _____

Patient Signature_____

Witness_____

I consent to have photos taken_____

Consent for use of Photographs/Slides/Videotapes

I hereby authorize Dr. John P. Stratis- Dr. Scott M. Gayner and/or his associates or licensees to use preoperative, intraoperative and post operative photographs, slides and/or videotapes for professional medical purposes deemed appropriate including but not limited to showing these images on public or commercial television, electronic digital networks, for purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups. I understand that I will NOT be entitled to

monetary payment or any other compensation as a result of any use of these images and/or my interview.

Date_____

Print Name_____

Patient Signature_____

Witness_____

I consent to have photos used_____

I DO NOT consent to have photos used _____