CONSENT FOR PHOTOGRAPHS AND PERMISSION TO OBSERVE SURGERY

Photographs of me or of part of my body will be taken by my physician or a photographer chosen by him. These photographs will be used for medical records.

Additionally, I consent that these photographs may be used in the following manners if in the judgment of the physician's medical research, education, or science will benefit by their use; and provided that my name not be divulged.

1. Reproduction in medical texts or journals.
2. Showing in medical conferences.
3. Showing to health education meetings of non-medical audiences.
4. Use in promotional materials

Please cross out any of the above use you wish not to be made.

Date: _____

Patient: _____

Witness: _____

20072 SW Birch St Suite 110, Newport Beach CA 92660
Tel: 949-251-1502 • Fax: 949-251-1522
www.seifymd.com