

AUTHORIZATION AND CONSENT TO PHOTOGRAPH AND PUBLISH

I authorize Dr. Michael Baroody to photograph or permit other individuals he may designate to photograph _____ (patient name).

I hereby consent that photographs be taken of me by my physician or by a photographer approved by my physician. I understand these photographs will be used as part of the medical record and may be used for teaching or research purposes by my physician. Including any or all of the following:

1. Medical article or textbook
2. As a part of a scientific exhibit
3. To illustrate medical lectures given to medical students or other professional groups
4. To illustrate medical lectures given to the public
5. To illustrate articles appearing in lay publications on medical topics
6. To be used within the scope of my physician's practice to illustrate surgical results to other patients
7. To illustrate pre and postoperative surgical examples appearing on Dr. Michael Baroody's website

I understand that I will not be identified by name in any such use of these photographs.

I waive any right to compensation for the above uses. I hold the physician and his designees harmless from and against any claim for injury or compensation resulting from the activities authorized by this agreement.

Signature _____ Date _____

Legal next of kin / Relationship _____ Date _____

Witness _____