THE OTTAWA CLINIC
PLASTIC SURGERY
SKIN CARE & LASER CENTRE

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PHOTOGRAPHY CONSENT FORM

I, ______________________________ agree that The Ottawa Clinic (TOC) may take and use preoperative and postoperative photographs for confidential clinical record purposes and that such records shall remain part of my medical record. I understand that such photographs shall become the property of TOC and will be retained by TOC.

I fully and specifically grant my permission for the use of photographs and/or case information for the following additional purposes as indicated below.

As a result of this use, I understand that these photographs may appear in other related, updated or reprinted formats at any concurrent or future occasion. I understand that such consent is strictly on a voluntary basis. I understand a copy of this consent may be supplied with the images to any third party wherein they may be published or presented. I understand that some photographs may, by their representation, make me identifiable in appearance to others. I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images.

I authorize TOC to use my photographs and/or case information in the following educational and scientific settings:

- My surgeon's office patient educational materials
- My surgeon's personal website or webpage

I understand my right to revoke or refuse such authorization for the taking of photographs and/or release of such photographs. This consent may be revoked at any time by written request or completion of a new form.

By signing this form, I acknowledge my consent and I further recognize that this consent form will supersede any other photo consent forms with a date prior to the date written below.

____ ______________________
Patient Signature Date

____
Printed Name of Patient

____ ______________________
Signature of Practice Representative and Witness Date