SILK VISION
& SURGICAL CENTER

Consent for Medical Photography

I consent for medical photographs to be taken of my eyelids or face (or person for whom I am legal guardian). I understand that the information is required in my medical record to be shared with insurance companies as needed.

Only if you agree we may also use your photos for the purposes of teaching, presentations, marketing and publications such as brochures or our website. I understand that the image may be seen by member of the general public. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

By consenting to these medical photographs I understand that I will not receive payment from any party. Refusal to consent to photos being used for other than my medical record will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may contact:

Silk Vision and Surgical Center by writing to 3301 Woodburn Rd, Suite 308, Annandale VA 22003.

By signing this form below I confirm that this consent form has been explained to me in terms which I understand.

- ☐ I consent to these photos being used for my medical record
- ☐ I consent to these photos being used for sharing with my insurance companies
- ☐ I consent to these photos being used for teaching and presentation purposes
- ☐ I consent to these photos being used for marketing/publication use

Patient Signature _____ Date _____

Witness Signature _____ Date _____