



**MEDIA SERVICES**  
Medical Photography

ADDRESSEE: \_\_\_\_\_

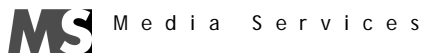
ADDRESS: \_\_\_\_\_

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FROM: \_\_\_\_\_ TELEPHONE NO. \_\_\_\_\_

HSC Media Services Level 3 Room 049 Stony Brook University Stony Brook, NY 11794-8030 Tel: 631. 444.3232 Fax: 631.444.6172



**PATIENT CONSENT TO PHOTOGRAPHY:**

For additional help or questions call: 444.3232

Job Number: \_\_\_\_\_



Print Name \_\_\_\_\_

I \_\_\_\_\_ hereby authorize the Department of Media Services at Stony Brook to take photographs of me or my child in whole or in part. I understand that these photographs may be used for medical or scientific purposes such as documenting or planning my care, teaching, research or publication in a scientific journal. I further understand that every attempt will be made to conceal my identity (name) prior to any publication or display of these images. I impose no restriction on the publication or use of these photographs except (completed by patient or write "none"):

I waive any rights I may have in such photographs as well as the privilege of approval of them or determining their final disposition.

\_\_\_\_\_  
Signature of Patient or  
Appropriate Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date