FRED WILDER, M.D.
CONSENT FOR USE OF PHOTOGRAPHS

Photographs will be taken before and after surgery for documentation. We would like to ask your permission to use these photographs to show future patients. This gives patients a realistic idea of the results they can expect should they choose to have a similar procedure. Rest assured that your identity will be kept confidential.

Initial the following:

_____Yes, you may use my photos

_____No, please do not use my photos

To facilitate surgery decisions, we upload your pictures to a password protected system called myTouchMD.

_____Yes, upload my photos to myTouchMD

_____No, please do not upload my photos to myTouchMD

I acknowledge that photographs may be taken of my body in connection with the medical services to be performed by my physician.

I have read the above policy and agree with it.

_____

Patient/ Parent/ Guardian Signature Date

_____

Name (Please Print)