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SYDNEY R. COLEMAN, M.D.

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CONSENT FOR TAKING AND PUBLICATION OF PHOTOGRAPHS

Patient:

Date:

In conjunction with the medical services which I am receiving from my physician, Sydney Reese Coleman, M.D., I consent that photographs may be taken of me or parts of my body, under the following conditions:

- 1.) The photographs may be taken only with the consent of Dr. Coleman and under such conditions and at such times as may be approved by him.
- 2.) The photographs shall be taken by Dr. Coleman or by someone approved by him and will remain his property.
- 3.) The photographs shall be used by Dr. Coleman to prepare for and evaluate surgery and if in the judgment of Dr. Coleman, medical research, education or science will be benefited by their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose which he may deem proper in the interest of medical education, knowledge or research, provided, however, that it is specifically understood that in any publication or use I shall not be identified by name without express and specific consent.

Patient Signature \_\_\_\_\_

Witness \_\_\_\_\_