Alexis Alexandridis M.D.
BREAST & GENERAL SURGERY

PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

PATIENT NAME: DATE OF BIRTH:

I consent for medical photography to be made of me (or person for whom I am legal guardian). I understand that the images will primarily be used for the medical record and in communication between physicians on my care team. Refusal to consent to medical photography will not affect the medical care I will receive. In some cases, medical photography will be shared in educational or promotional settings, and I will indicate my consent for these specifically, as indicated below. All images will be identified by a medical record number particular to Dr Alexandridis' records only. All reasonable attempts at privacy and confidentiality of the images will be made. The photographs will be collected on a device that does not leave the clinical space and will be downloaded to a secure, HIPAA-compliant electronic health record.

Please INITIAL next to the items to which you give your consent for medical photography:

____ Medical Record of Dr Alexandridis and her professional colleagues as indicated for my direct medical care.

____ Promotional materials to share with other potential patients. (These images would be used without identifying information to protect privacy.)

____ Educational activities, like journal publications, medical professional presentations, etc. (These images would be used without identifying information to protect privacy.)

SIGNATURE:_____ DATE: _____

RELATION TO PATIENT: _____

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