

Patient Photographic and Videographic Consent, Authorization and Release Form

I am informed and aware of photographs, videos and other images (imaging records) taken by Dr./Nurse _____ or his/her designee(s) of myself or any parts of my body regarding procedures carried out by Dr./Nurse _____ or his/her team. I understand and consent that such imaging records may and will be used by Dr./Nurse _____ as reference in diagnosing and treating other patients in the future. I further consent to the release and transfer of copyright ownership by Dr./Nurse _____ to the Korean Wound Management Society (“KWMS”) of such imaging records.

I understand that by consenting on release of my imaging records, these may be published by KWMS and/or any party acting under the license and authority of KWMS in any print, electronic or broadcast media, specifically including, but not limited to, medical journals (especially the Journal of Wound Management and Research “JWMR”) and textbooks, scientific presentations and teaching courses and Internet websites, for the purpose of informing medical professionals or the general public about wound management method, results, issues, trends, concerns and similar matters. I further understand that the imaging records shall become the property of KWMS.

I understand that when these imaging records are included in any articles, medical information regarding sex, age, operative date and treatment results may and will be included together. I also understand that neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the images or medical information may portray features which shall make my identity recognizable. Further, I recognize that in some instances the images may be transformed into a non-photo likeness of me.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it may not have any effect on actions taken prior to my revocation. If I do not revoke this authorization, it will expire ten years from the date written below. I also understand that I may refuse to sign this authorization and that whether I consent on this form or not will have no effect on the medical treatment I receive from Dr./Nurse _____ or any subordinates.

I release and discharge Dr./Nurse _____, KWMS, and all parties acting under their license and authority from all rights that I may have in the imaging records and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution of publication of the images in any medium or claim arising from the distribution of publication by any third party.

I hereby warrant that I am over nineteen years of age, and competent to contract in my own name.

I grant this consent as a voluntary contribution in the interest of public education, and certify that I have read the above Consent, Authorization and Release form and fully understand its terms.

Patient Photographic and Videographic Consent, Authorization and Release Form

Name : _____

Signature : _____

Date : _____

Hospital : _____

Designated Dr./Nurse : _____

Signature : _____

I have read the above Consent, Authorization and Release. I am the parent, guardian or conservator of _____, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

Parent/Guardian _____

Signature : _____

Date : _____