

**Patient Consent for Medical Photography**

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Birth:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose of Consent**

This consent form allows Tucson Breast Health Specialists to take and use photographs of your surgical site for medical purposes, including but not limited to documentation, education, and treatment planning.

**Consent to Photograph**

I, the undersigned, consent to the taking of photographs of my surgical site. I understand that these photographs may be used for medical documentation and treatment planning, education and training of healthcare professionals. This is to include any photographs I provide.

**Confidentiality**  
I understand that all photographs will be kept confidential and will only be shared with authorized personnel involved in my care. My identity will be protected in any educational materials.

**Right to Withdraw Consent**  
I understand that I may withdraw my consent at any time by notifying Tucson Breast Health Specialists in writing. Withdrawal of consent will in no way affect the medical care I receive.

**Signature**  
By signing below, I confirm that I have read and understood this consent form. I agree to the terms outlined above.

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Witness Signature (if required):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_