ATLANTA OTOLOGY

Patient Photograph and Video Release Form

I understand that photographs and/or videos may be taken of me or parts of my body during surgery **to educate the public or other physicians about ear surgery.**

These images/videos may be shared with staff, other physicians or healthcare professionals and members of the public for educational and marketing purposes. Photos and/or videos may be used for scientific presentations or journal publications. They may also be posted online on the practice website or social media websites for educational purposes. I understand that once video/photos are published, I lose control and rights to these images/videos.

My name or identifying information will be kept confidential. However, some of my medical information including history, physical exam, and results of medical tests may be mentioned for educational purposes.

I hereby give my consent for Dr. Yohan Song to record and publish my surgery as outlined above.

Patient Name: _____

Patient DOB: _____

Patient or Guardian Signature: _____

Date: _____