

PHOTOGRAPHIC CONSENT

I authorize____ / do not authorize____, JOHN L. LeROY, JR., MD, to obtain pre-operative, operative and post-operative photographs as deemed necessary for the complete documentation and illustration of the case involved.

I understand that these photographs may appear in medical publications or conferences in the interest of medical education, knowledge or research. Although permission is given for the publication of details and pertinent photographs concerning my case, I understand that I will not be identified by name.

Patient

Date

Witness