כתב העת הישראלי לרפואה דחופה

Israeli Journal of Emergency Medicine

Consent for Medical Photography

Subject Name:_____

Date: _____

I consent for medical photographs to me made of me or the person for whom I am legal guardian. I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in the Israeli Journal of Emergency Medicine (print and on-line edition).

By consenting to these medical photographs I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive.

_____ _____

Print Name of Signatory Signature

_____ _____

Print Name of Witness Signature