Consent for Clinical Photography

I hereby assign to **Mr Vempali**, the rights to photos, film, videotapes, or other visual images taken as part of patient care services obtained.

I understand that the intended use of the visual images is for clinical record keeping and educational purposes and may include publication at presentations and in journals or placement of websites for the purpose of teaching in ophthalmology. I understand that I will have no claim to future compensation, benefits, rights, or royalties.

I have executed this document voluntarily and understand that I may refuse to execute this document, and such a refusal will not affect the care received or access to patient care.

I understand that I may revoke this authorization by writing to Mr Vempali. I understand that we may not revoke this authorization to the extent the use or disclosure of the medical record information has already been made. This authorization does not expire unless I revoke it.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND THAT I UNDERSTAND THIS AUTHORIZATION FORM.

_____

Signature of Adult Participant

OR

_____

Signature of Legal Guardian of Participant

Address