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Patient Consent for Publication of Photograph or Other Information

Patient name: _____
(Please print) (Last) (First) (Middle initial)

By signing below, I hereby give the American Academy of Family Physicians (AAFP) the right and permission to publish my photograph and other material in *American Family Physician* and associated publications and, if so indicated below, on the *American Family Physician* Web site. I have seen the photograph and material to be published, a copy of which is attached, and hereby approve both. I transfer copyright of this material to the AAFP. Accepted manuscripts become the property of the AAFP and may not be published elsewhere without the written permission of the AAFP.

I understand the following:

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- My full name will not be published (in print or on the Web site).
- The material and photograph will not be used for advertising or promotional purposes of any kind.
- The material and photograph will not be used out of context (example: the photograph will not be published in an article that is unrelated to the subject of the photograph).

My consent outlined above DOES DOES NOT (check one) include consent to the use of my material and photograph on the *American Family Physician* Web site.

Address: _____

Telephone number: _____ E-mail address: _____

Signature: _____ Witness: _____ Date: _____

If patient is under 18 years of age, the signature of parent or guardian is required below:

Parent/Guardian Signature _____ Witness: _____ Date: _____

Relationship to minor child: _____ Date: _____

AFP Use Only:	Date received:	Issue date:
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