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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 Accepted manuscripts become the property of the AAFP and may not be published elsewhere without the written permission of the AAFP.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:

- *American Family Physician* is published by the American Academy of Family Physicians twice each month. It is mailed to approximately 180,000 physicians in the United States and some foreign countries.
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- If deemed appropriate, the American Academy of Family Physicians may grant permission for articles in *American Family Physician* to be translated into other languages and distributed to physicians in foreign countries.
- My full name will not be published (in print or on the Web site).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- The material and photograph will not be used out of context (example: the photograph will not be published in an article that is unrelated to the subject of the photograph).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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