



Alan Y. Yan, MD, FAAOS

SOCIAL MEDIA / PUBLICATION CONSENT FORM

Name: _____

Date of Birth: / /

Gender: M F

Hospital M.R.N. number: _____

I consent for digital medical imaging (photography and/or video recording) to be made of me related to my specific health conditions under the care of Dr. Alan Y. Yan and his care team.

I understand that the information may be used in my medical record, for purposes of medical teaching, publication in medical textbooks, journals, and social media as I have consented below.

My refusal to consent to photographs and video recordings will in no way affect the medical and/or surgical care I will receive. If I have any questions or wish to withdraw my consent in the future, I may contact the hospital and Dr. Alan Y. Yan’s care team.

I hereby consent to the use of my photographs and video recordings in medial publications, including but not limited to medical journals, textbooks, electronic publications, and social media. I understand that the photographs and videos may be seen by members of the public. Although the photographs and video recordings will be used without identifying information such as my name or any unique identifying features (i.e., tattoo or scars), I understand that it is possible that someone may recognize me. I also agree for my images to be used for teaching purposes and to be used in my medial record.

Patient/Parent/Guardian Signature: -

Date: _____