**Consent to Take and Release Photographs**

Medical photographs may be taken before, during or after a surgical procedure or

treatment. Consent is required to take such photographs.

Patients may consent to release this medical photography for a stated

purpose.

I hereby authorize Milan Eye Center, and/or associates or licensees to take pre-operative,

intra-operative, and post-operative photographs, as well as consent to

photographs of my interview.

I hereby authorize Milan Eye Center, and/or associates or licensees to use

pre-operative, intra-operative and post-operative photographs for professional medical

purposes deemed appropriate, including but not limited to purposes of medical

education, patient education, lay publication, or lectures to medical or lay groups.

I understand that I will not be entitled to monetary payment or any other consideration as

a result of any use of these images and/or my interview.

**Consent for Treatment**

I hereby voluntarily consent to the rendering of care by the doctors and authorized

members of Milan Eye Center, including diagnostic procedures and medical treatment as

necessary in their professional judgment.

I hereby acknowledge that no guarantees have been made to me as to the effect of such

examinations or treatment to my condition.

I acknowledge that I am responsible for all reasonable charges in connection with care and

treatment rendered by Milan Eye Center.

**By signing, I understand and acknowledge the above policies.**

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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