The Podiatry Doctors

Dr. Neal Bullock, D.P.M.
Dr. Adam Oxios, D.P.M.

17013 Pines Boulevard Pembroke Pines, FL 33027
Office: (954) 450-4200 Fax: (954) 450-4237

CONSENT & RELEASE OF MEDICAL PHOTOGRAPHY/VIDEOS

I hereby authorize Dr. Neal Bullock, DPM and Dr. Adam Oxios, DPM to use pre-operative, intra-operative and postoperative photography/video for publication or republication in any print visual or broadcast media, including, but not limited to, showing these images on public or commercial television, electronic digital networks, social media, the Internet, and websites or web pages, for purposes of medical education, patient education, viewing by perspective patients, lay publications, publications for marketing and/or advertising, newspaper and magazine articles, or during lectures to medical or lay groups.

Neither I, nor any member of my family, will be identified by name in any publication. Although measures will be taken to reduce or illuminate identifying features, the possibility remains that someone may recognize me.

I discharge all rights that I may have in the photographs/videos and I release and discharge, Dr. Neal Bullock, DPM, Dr. Adam Oxios, DPM and the practice entity at which they work, it's assigns and licenses, from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs/videos.

I understand that if I allow my images/videos to be used in publications, I have the right to revoke this consent up until the time the images are excepted for publication. Once the images/videos have been published, I may not revoke my consent. Anonymity cannot be guaranteed in publications.

I have been provided the opportunity to ask questions concerning medical photography/video and understand that refusal to consent will not affect my medical care. If the patient is under 18 years of age, I verify that I am the parent or guardian of the patient and that I will sign for the patient.

I certify that I have read the above authorization and release and fully understand its terms intending to be legally bound hereby.

_____ I agree and authorize the use of my photos/videos

Signature of Patient:_____ Date:_____

Patient Name:_____