CONSENT FOR PHOTOGRAPHY, VIDEOTAPING, OR OTHER IMAGING FOR MEDIA OR EDUCATIONAL PURPOSES

NOTE: THIS CONSENT IS VOLUNTARY AND NOT A REQUIREMENT TO BE SEEN BY OUR OFFICE. IF YOU DO NOT CONSENT TO PHOTOGRAPHY, PLEASE DO NOT SIGN

THIS FORM.

By signing this form, I give my consent to have photographs, videotaped images, or other images taken by representatives of our office for non- medical management purposes. Although these photographs will be used without identifying information such as my name, date of birth, or address, I understand that someone may recognize me. I understand and agree that these images may be used by our office for the following purposes:

• Teaching purposes, which includes being shown to students, residents, other physicians, or other patients.

• Advertisements by Podiatry Health Services LLC. • Placement on our office's website or social media platforms.

I understand that my decision is voluntary. I may rescind my consent for photography, videotaping, or other imaging at any time. Refusal to consent to photographs or video will in no way affect the medical care I receive. Although these photographs will be used without identifying information such as my name, I understand that someone may recognize me.