**Imaging Consent:**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I consent to the use of my medical images to be used for the purposes of medical teaching, or for publication in medical textbooks or journals, electronic publications or educational presentations. By consenting to this use, I understand that I will not receive payment from any party for the use of my images. I understand that these images may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. I understand that these images will be used without any identifying information such as my name. Refusal to consent to the use of my medical images will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future, I may contact:

Jeffrey A. Strakowski, M.D.

1210 Gemini Place, Suite 200

Columbus, OH 43240

614-324-8177

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**