

# Authorization for Video and Pictures

I, \_\_\_\_\_, understand that in the course of my surgery, video pictures and/or still pictures may be taken. These video pictures and/or still pictures are the sole property of Dr. Joseph M. Berman and may be used by him for educational, promotional or other use as he, in his sole discretion, may deem appropriate. My name will not be used and my privacy will be maintained at all times. I further relinquish all rights, both present and future, to these same video pictures and/or still pictures.

\_\_\_\_\_  
Patient/Guardian

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Name Printed

\_\_\_\_\_  
Date