Case 1

Registration No.	[redacted]
Name	[redacted]
Age/Gender	[redacted] Room No. [redacted]
Date of birth	[redacted]
Medical department	[redacted] 성형외과
Professor in charge	[redacted] 강재수

Consent Form for Clinical Photography and Video Recordings

Region	[redacted]	Department	
Scheduled date	[redacted]	Physician	

■ **The purpose of collection and use of personal information**

[Treatment and educational purpose]

I consent to the use of my before and after photographs and video recordings for treatment and teaching purpose.

☑ Agree ☐ Disagree

[For advertising and publicity]

I consent to the use of my before and after photographs and video recordings in publications including Konyang university hospital's advertisements and for other patients' treatment. ☑ Agree ☐ Disagree

■ **Items of personal information collection**

Photos or video recordings before and after surgery/procedure

■ **Period of maintenance and use of collected personal information**

Personal information is retained for a period of time under the related law and may be retained indefinitely.

■ **Refusal right and disadvantages of refusal**

- You have the right to refuse to provide your information, refusal to consent to photographs will in no way effect the medical care you will receive.
- Personal information would not be used for other purposes except for what you agreed to and you can ask the staff to read or delete it.

I fully understand this agreement and grant consent to collect and use my personal information according to 「PERSONAL INFORMATION PROTECTION ACT」 and the related law as stated above.

[redacted]

Patient or Guardian (patient's): [redacted] (signature)

Contact 1 : [redacted] Contact 2 : _____

☞ **Reasons for the signing of this letter of consent by the Guardian**

☐ It is determined that the patient would not be able to understand photograph and video due to physical and mental disability

☐ It is determined that the patient would not be able to understand the surgical procedure because the patient is a minor.

☐ It is determined that provision of the explanation may impart materially adverse effect on the mind and body of the patient.

☐ The patient has authorized the rights regarding the approval and consent to a particular person.

☐ Emergency situation

☐ Miscellaneous: _____

[redacted]

[redacted]

#CURRENT_DAYTIME_KO

To: Director of the [redacted]

Doctor providing explanation:

[redacted]

Case 2

Registration No.	[redacted]
Name	[redacted]
Age/Gender	[redacted] Room No. [redacted]
Date of birth	[redacted]
Medical department	[redacted] 성형외과
Professor in charge	[redacted] 김규남

Consent Form for Clinical Photography and Video Recordings

Region	[redacted]	Department	
Scheduled date	[redacted]	Physician	

■ **The purpose of collection and use of personal information**

[Treatment and educational purpose]

I consent to the use of my before and after photographs and video recordings for treatment and teaching purpose.

☑ Agree ☐ Disagree

[For advertising and publicity]

I consent to the use of my before and after photographs and video recordings in publications including Konyang university hospital's advertisements and for other patients' treatment. ☑ Agree ☐ Disagree

■ **Items of personal information collection**

Photos or video recordings before and after surgery/procedure

■ **Period of maintenance and use of collected personal information**

Personal information is retained for a period of time under the related law and may be retained indefinitely.

■ **Refusal right and disadvantages of refusal**

- You have the right to refuse to provide your information, refusal to consent to photographs will in no way effect the medical care you will receive.
- Personal information would not be used for other purposes except for what you agreed to and you can ask the staff to read or delete it.

I fully understand this agreement and grant consent to collect and use my personal information according to 「PERSONAL INFORMATION PROTECTION ACT」 and the related law as stated above.

[redacted]

Patient or Guardian (patient's): [redacted] (signature)

Contact 1 : [redacted] Contact 2 : _____

☞ **Reasons for the signing of this letter of consent by the Guardian**

☐ It is determined that the patient would not be able to understand photograph and video due to physical and mental disability

☐ It is determined that the patient would not be able to understand the surgical procedure because the patient is a minor.

☐ It is determined that provision of the explanation may impart materially adverse effect on the mind and body of the patient.

☐ The patient has authorized the rights regarding the approval and consent to a particular person.

☐ Emergency situation

☐ Miscellaneous: _____

[redacted]

[redacted]

[redacted]

[redacted]

Doctor providing explanation:

[redacted]

[redacted]