**CONSENT FORM – MFR treatment**

1. I the undersigned, hereby confirm that I have requested and engage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Doctors/Institution) to place implants and manufacture prosthetics for reconstruction of my defect.

2. I acknowledge and confirm that conventional photographs and diagnostic radiological, magnetic resonance and/or sonar imaging (collectively referred to as “*the imaging*”) will probably be necessary and performed on me before, during and after the completion of the surgery.

3. I acknowledge and confirm that my records and pictures can be used for teaching and academic purposes, including medical publications and conferences.

4. I hereby irrevocably agree and give my consent and permission to the doctors and any of their third-party service providers, employees, assistants, helpers, representatives or agents to be present during my treatment if their expertise and knowledge will aid in my treatment and to make use of and publish data and images my clinical records, for the purposes set out in clause 3 above, at their sole discretion.

5. Every attempt will be made not to disclose the identity of the patient.

SIGNED AT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ON THIS \_\_\_\_\_\_\_\_\_\_\_ DAY OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 20\_\_\_\_\_\_

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(name) (Signature)