AUTHORIZATION FOR THE USE OF PHOTOGRAPHS

Your surgery has been photographically documented before, possibly during and after the procedure. These photographs are a permanent part of your medical record and will never be shown to anyone else without your consent.

For various reasons, Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is often asked to show before and after photos of his patients. Many patients are happy with their results and are asked to give us permission to share their photos anonymously. Please consider authorizing the use of your photos in the following categories. If you consent to any of the following uses of your photos, please circle “Yes”. Your signature is considered your authorization for the sharing of your photographs.

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Procedure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*The following uses are anonymous*

1. Sharing with other patients in the office: Yes No
2. Sharing in publications, articles, health fairs, or lectures: Yes No
3. Sharing on our company website: Yes No
4. Sharing on other internet sites for the benefit of plastic surgery patients: Yes No

I understand that every attempt will be made to represent me and Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ accurately and with integrity and dignity in all media. I herby certify that I have read the foregoing and fully understand its meaning and effect.

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_