

PHOTOGRAPHIC RELEASE AND CONSENT

I, _____ agree that Artisan Plastic Surgery may take and use preoperative and postoperative photographs for confidential clinical record purposes, and that such photographs shall remain part of my medical record.

Patient Signature

Date

I fully and specifically grant my permission for the use of photographs, and/or case information for the following additional purposes as indicated by my initials below. As a result of this use I understand that these photographs may appear in other related, updated or reprinted formats at any concurrent or future occasion. I understand that such consent is strictly on a voluntary basis. I understand a copy of this consent may be supplied with the images to any third party wherein they may be published or presented. I understand that some photographs may, by their representation make me identifiable in appearance to others. I authorize Artisan Plastic Surgery to use my photographs and/or case information in the following educational and scientific settings that I have initialed:

Facial Breast
Surgery Body

- | | | |
|--------------------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | My surgeon's office patient education materials |
| <input type="checkbox"/> | <input type="checkbox"/> | My surgeon's file of pre and postoperative patient photographs available to prospective patients for viewing in the office |
| <input type="checkbox"/> | <input type="checkbox"/> | Newspaper and magazine articles in which my surgeon participates |
| <input type="checkbox"/> | <input type="checkbox"/> | Television in which my surgeon participates |
| <input type="checkbox"/> | <input type="checkbox"/> | My surgeon's personal web site or web page |
| <input type="checkbox"/> | <input type="checkbox"/> | Lectures and multimedia presentations given by my surgeon for the general public |

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

Date

Signature of Practice Representative and Witness

Date