AUTHORIZATION FOR THE USE OF PHOTOGRAPHS

The use of photographs is essential to the planning and evaluation of our cosmetic treatments and services. Your procedure has been photographically documented before, possibly during and now after the treatment or service. These photographs are a permanent part of your medical record and will never be shown to anyone else without your consent.

Many of our patients have given permission to use their photograph anonymously for the purpose of educating other patients and for promotional purposes. No names or other specific identifying information will ever be disclosed. It is understood that for facial procedures, someone may be able to recognize your picture.

Name: _____

Procedures that you have had done:

1._____

2. _____

3. _____

☐ I authorize the **anonymous use** of my photograph to show prospective patients before and after pictures in the office for the purpose of choosing a surgeon/clinic and evaluating specific procedures.

Procedure #1: YES / NO Procedure #2: YES / NO Procedure #3: YES / NO

☐ I authorize the **anonymous use** of my photograph on the internet or other electronic and print media for the purpose of patient education, doctor education, and promotions. This includes uses such as our business web sites, social media web sites, newsletters, and other print materials.

Procedure #1: YES / NO Procedure #2: YES / NO Procedure #3: YES / NO

I understand that every attempt will be made to use these photos accurately with integrity and dignity on all occasions. I hereby certify that I have read the foregoing and fully understand its meaning and effect.

Patient Signature: _____ Date: _____

Name Printed: _____

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