Authorization For And Release Of Medical Photographs, Video, Social Media, eSSe Website

This is a consent document that has been prepared to help inform you concerning granting permission to take photographs and to use these images for a purpose as defined within this consent document. Upon review, please sign the consent as proposed by your Medical Provider. Medical photographs may be taken before, during, or after a surgical procedure or treatment. Consent is required to take such images. This practice has a policy requiring all patients seeking elective surgery to undergo preoperative photography at a minimum as part of prudent record keeping, to permit appropriate surgical planning. Elective cosmetic surgery may be denied to patients who refuse medically necessary preoperative photography.

1. CONSENT TO TAKE PHOTOGRAPHS
I hereby authorize the surgeon and the surgeon's associates or licensees to take pre-operative, intra-operative, and post-operative photographs. I additionally consent to photographs during my consultation/office visit.

2. CONSENT FOR RELEASE OF PHOTOGRAPHS
I hereby authorize the surgeon and the surgeon's associates or licensees to use pre-operative, intra-operative, and post-operative photographs for professional medical purposes deemed appropriate. These include, but are not limited to, showing photos as part of medical literature or presentations to medical colleagues, publication in medical or surgical journals as part of research (separate consent to participate in research must be obtained), patient education in the office or in published materials, or during lectures to lay groups. This also may include posting these pictures or video on the Internet (social media, eSSe website) to educate other prospective patients. For most procedures, there are no faces shown or identifiable marks shown. This office guards patient privacy vigorously. I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images.

I understand I may revoke permission for future use of these images at any time. If I revoke this permission, the surgeon's office will make every good faith effort to remove these images from websites to which the office published the images. However, due to the nature of the Internet, it may not be possible to remove all images from distribution. I agree to hold the doctor, office, practice and staff harmless for any unintended use of such photos that may stem from unauthorized use or distribution by others.

By my signature, I hereby acknowledge receipt and understanding of this form.

_____ _____

Witness Signature Patient/Agent/Guardian Signature

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Date