Release to Take and Use Photographs

PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TREATMENTS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Photographs will be taken for documentation purposes, and will become part of your medical record.

Do you authorize Steven Holzman, MD PA to use your photos in the following ways :

Circle your answer and initial.

Yes No For the purposes of teaching and/or research (your identity *will not* be revealed)?

\_\_\_\_\_\_\_\_\_\_\_\_\_ (initial)

Yes No For display on our website (your identity *will not* be revealed)? \_\_\_\_\_\_\_\_\_\_­­­­­­­­­\_\_\_ (initial)

Yes No For use in print advertisements (your identity *will not* be revealed)? \_\_\_\_\_\_\_\_\_\_\_\_\_ (initial)

*I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient (or Person Authorized)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Physician or Assistant