become
HOLZMAN PLASTIC SURGERY

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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 and social media platforms (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