



PHOTOGRAPH RELEASE

PATIENT NAME: _____ CHART # _____

In connection with and in consideration of the medical services which I have been receiving or am about to receive from David V. Pratt, M.D., Troy J. Woodman, M.D., or Frederick W. Ehret, M.D., I hereby consent to clinical photographs being taken of me under the following conditions: (Please initial each statement)

- _____ 1. Photographs may be taken preoperatively, during and after any treatment or surgery I may undergo.
- _____ 2. Photographs shall be taken only with the consent of my physician and under such conditions and at times maybe approved by my physician.
- _____ 3. Photographs may be used for medical purposes and remain the property of my physician.
- _____ 4. If, in the judgment of my physician, medical research education or science will be benefited by their use, these photographs and information relating to my case may be published or used for other educational or professional purpose which my physician may deem proper, provided, however, that I shall not be identified by name in any such publication or use.
- _____ 5. I consent to have my pictures displayed on the Aesthetic Surgery Centre website, in the physician reference books, and in the practice marketing and advertising materials. I understand my name will not be included.

I hereby release any persons participating in my case from any and all liability which may or could arise from the taking or authorized use of such photographs.

PATIENT SIGNATURE WITNESS DATE

Because the patient is an un-emancipated minor, _____years of age, or is able to sign for the following reasons: _____

The above consent is given on the patient's behalf by:

CLOSEST RELATIVE OR RELATIONSHIP
GUARDIAN SIGNATURE

DATE WITNESS