

## ***Institute of Facial and Cosmetic Surgery***

### Consent to Photograph

1. I hereby authorize Doctors and/or his employees or associates to photograph me, take motion pictures, television pictures, videotape, electronic, digital or computer recordings or reproductions of me. (All of the aforementioned will be hereinafter referred to as photographic or electronic reproductions.) This authorization includes the taking of photographic or electronic reproductions of any part of my body.
2. The photographs shall be used for my medical records, and if in the judgment of my physician, medical research, education or science will be benefited by their use, such photographs and information relating professional journals or medical books, or used for any other purpose which he may deem proper in the interest of medical education, knowledge or research: provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name.
3. I authorize the use of any such photographic or electronic reproductions of me for any purpose, including by not limited to scientific or educational purposes, including publications or reproduction in all forms of media, whether public or private including the internet; provided, however, that it is specifically understood that I shall not be identified by name. I understand that I may be identifiable from such photographic or electronic reproductions.
4. The aforementioned photographs may be modified or retouched in any way that my physician, in his directions, may consider desirable.
5. I understand that I may refuse to consent to the taking of photographic or electronic reproductions or that I may limit the taking or use or any such photographic or electronic reproductions without prejudice to my care. I do not impose any limitations except (list any limitations you wish to impose.)

---

6. Unless the patient states otherwise in writing; this consent will be considered valid for the taking of all photographs or electronic reproductions for up to three years after the date of signing and it will not e necessary to obtain any further written consent for photographs or electronic reproductions during that three year period of time.

**I understand all of the above information and have reviewed all of this material with my physician. All of my questions at this time have been answered.**

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_