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PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I consent to the release of the photographs taken of me, or parts of my body, to the Plastic Surgery Center, PA, with respect to my plastic surgery treatment.

I understand that such photographs shall become the property of Plastic Surgery Center, PA and may be retained by, or released by Plastic Surgery Center, PA for PUBLICATION OR REPUBLICATION in any PRINT, VISUAL, ELECTRONIC (INTERNET WEB SITE) OR BROADCAST MEDIA for any purpose which the Plastic Surgery Center, PA deems appropriate to inform the medical profession or the general public about plastic surgery methods. The media may include, but are not limited to, the following: MEDICAL JOURNALS AND TEXTBOOKS, PAMPHLETS, NEWSPAPERS, MAGAZINES, and VIDEO TAPES.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that shall make my identity recognizable.

I release and discharge the Plastic Surgery Center, PA and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I have relating to such use and publication, including any claim for payment in connection with distribution or publication of the photographs.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above authorization and release and fully understand its terms.

PATIENT SIGNATURE_____DATE_____

WITNESS_____

I have read the Authorization and Release. I am the parent, guardian or conservator of_____, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.