

**AUTHORIZATION FOR AND RELEASE OF
MEDICAL PHOTOGRAPHS/SLIDES AND/OR VIDEOTAPES**

INSTRUCTIONS:

This is a consent document that has been prepared to help inform you concerning permission to take photographs, slides, and/or videotapes and to use these images for a purpose as defined with this consent document.

It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by your plastic surgeon.

INTRODUCTION:

Medical photographs, slides, and/or videotapes may be taken before, during or after surgical procedure or treatment. Consent is required to take such images.

Additionally, patients may consent to release these medical photographs, slides, and/or videotapes for a stated purpose.

1. CONSENT TO TAKE PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize **Gregory J. Mackay, M.D., M. Susann Bedford, M.D., or Donald R. Nunn, M.D.** and his associates or licensees to take pre-operative and post-operative photographs, slides, and/or videotapes. I additionally consent to photographs, slides and/or videotapes of my interview.

****2. CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPES**

I hereby authorize **Gregory J. Mackay, M.D., M. Susann Bedford, M.D., or Donald R. Nunn, M.D.** and his associates or licensees to use pre-operative, intra-operative and post-operative photographs, slides and/or videotapes for professional medical purposes deemed appropriate including but not limited to showing these images on electronic digital networks for purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups. _____ INITIALS.

****PLEASE NOTE THAT THIS SECTION IS OPTIONAL****

****YOU MUST STILL SIGN CONSENT FOR ABOVE SECTION****

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and/or my interview.

Date _____

Patient Signature _____

Witness _____