

PATIENT PHOTOGRAPH RELEASE FORM

Patient's Name _____

I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after surgery. The photographs will be taken by one of the members of the Perimeter Plastic Surgery staff. I hereby give my consent for Perimeter Plastic Surgery, L.L.C. to use the photographs under one of the following circumstances:

Please initial ONE of the following:

ALL MEDIA

_____ Photographs taken of me or parts of my body as well as details regarding medical services I have received at Perimeter Plastic Surgery, L.L.C. may be used in any print or broadcast media, including but not necessarily limited to newspapers, pamphlets, educational films, our internet site and television, in order to inform the public about plastic surgery methods. Further, I release and discharge Perimeter Plastic Surgery, L.L.C., the facility used and the American Society of Plastic Surgery, and all parties acting under their license and authority from any and all claims or actions that I have or may have relating to such use and publication and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

WEBSITE ONLY

_____ Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Perimeter Plastic Surgery, L.L.C. may be used on our internet website in order to inform the public about plastic surgery methods. Further I release and discharge Perimeter Plastic Surgery, L.L.C. , and employees of Perimeter Plastic Surgery, L.L.C. , any facility used and the American Society of Plastic Surgery, and all parties acting under their license and authority from any and all claims or actions that I have or may have relating to such use and publication and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

PHOTO ALBUM ONLY

_____ Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Perimeter Plastic Surgery, L.L.C. may be used in the photograph album in order to inform other patients of Perimeter Plastic Surgery, L.L.C. about plastic surgery methods. Further I release and discharge Perimeter Plastic Surgery L.L.C., and employees of Perimeter Plastic Surgery L.L.C., any facility used and the American Society of Plastic Surgery, and all parties acting under their license and authority from any and all claims or actions that I have or may have relating to such use and publication and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment in connection with any such use or publication in the photograph album. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject to only the condition that I am not identified by name at any time during any use of these materials by any party.

MEDICAL CARE ONLY

_____ Photographs taken of me or parts of my body can be used solely for the purpose of my medical care with Perimeter Plastic Surgery, L.L.C. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at Perimeter Plastic Surgery, L.L.C.

Date _____

Witness _____

Patient or Guardian Signature _____