Patient Photograph Release Form

Patient Information

Patient’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Photograph Consent and Release

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 Park Avenue Oculoplastics

I hereby give my consent for Park Avenue Oculoplastics to use the photographs under one of the following circumstances.

Please initial one

of the following:

\_\_\_\_\_\_\_\_ Internet:

Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Washington Oculoplastics can be used on the company’s website in order to inform the public about plastic surgery methods. Further, I release and discharge Washington Oculoplastics , any employees of Washington Oculoplastics 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 or any other identifying marks at any time during any use or publication of these materials by any party.

\_\_\_\_\_\_\_\_ All Media:

Photographs taken of me or parts of my body as well as details regarding medical

services that I have received at Washington Oculopalstics., can be used in any print or broadcast media, including, but not necessarily limited to newspapers, pamphlets, educational films, internet, and television, in

order to inform the public about plastic surgery methods. Further, I release and discharge Washington Oculoplastyics 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.

\_\_\_\_\_\_\_\_ Medical Care Only:

Photographs taken of me or parts of my body can be used solely for the purpose of my medical care with Washington Oculoplastics. The photographs and all details regarding

medical services rendered to me will be kept confidential within my personal medical history file at Washington Oculoplastics

By signing this form, I acknowledge my consent as initialed above, and I further recognize that this consent

form will supersede any other photo consent forms with a date prior to the date written below.

This consent may be revoked at any time by written request or by

completion of a new form.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_