

**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 within 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 videotapes may be taken before, during, or after a surgical procedure or treatment. Such photography is very important for planning procedures and for documentation. Consent is required to take such images. Your pictures will never be used for anything for which you do not consent. Dr Rose will not be able to perform your surgery if he is not allowed to use photographic documentation.

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

1. CONSENT TO TAKE PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize Kevin Rose, M.D. and/or his associates or licensees to take pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes. I additionally consent to photographs, slides, and/or videotapes as part of my interview.

2. CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize Kevin Rose, M.D. and/or 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 public or commercial television, electronic digital networks, for purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups. Every attempt will be made to conceal each patient's identity.

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: _____