Authorization For Release and or Publication of Photographs

Option 1:
I hereby authorize the release and/or publication of photographs that may be taken pre-operatively, during surgery, or post-operatively, without limitation regarding my physical and mental condition. I consent to these photographs being available for patient viewing, teaching, and/or advertising.

Name Date

Address

City State Zip

Patients or Legal Guardian's Signature Date

Witness' Signature Date

Option 2:
I consent for my photographs to be used for:

Teaching
Patient viewing/education
Other ________________________

Patients or Legal Guardian's Signature Date

Witness' Signature Date