PATIENT CONSENT AND RELEASE OF MEDICAL PHOTOGRAPHY

I hereby authorize Bellissimo Plastic Surgery, LLC (“Bellissimo”) to use pre-operative, intra-operative and post-operative photography for publication, or republication, in any print, visual or broadcast media, including, but not limited to, showing these images on public or commercial television, electronic digital networks, the Internet, and web sites or web pages, for purposes of medical education, patient education, viewing by perspective patients, lay publications, publications for marketing and/or advertising, newspaper and magazine articles, or during lectures to medical or lay groups.

Neither I, nor any member of my family, will be identified by name in any publication. Although measures will be taken to reduce or eliminate identifying features, the possibility remains that someone may recognize me.

I discharge all rights that I may have in the photographs and I release and discharge, Bellissimo, its assigns and licenses, from any claim that I may have relating to such use and publication, including any claim for payment in connection with distribution or publication of the photographs.

I understand that if I allow my images be used in publications, I have the right to revoke this consent up until the time the images are accepted for publication. Once the images have been published, I may not revoke my consent. Anonymity cannot be guaranteed in publications.

I have been provided the opportunity to ask questions concerning medical photography and understand that refusal to consent will not affect my medical care. If the patient is under 18 years of age, I verify that I am the parent or guardian of patient and that I will sign for the patient.

I certify that I have read the above authorization and release and fully understand its terms, intending to be legally bound hereby.

Initials

_____ I agree and authorize the use of my photos.

_____ I DO NOT authorize the use of my photos.

Signature of Patient (Parent/Guardian): ________________________________

Patient Name: ________________________________

Date: ______________

Witness: ________________________________