Photo Consent

Medical Photo Consent

I hereby give Dr. Tanya A. Atagi and the staff the absolute permission to photograph myself, for the medical reason(s) indicated at my consultation, and for pre and post-operative care, only.

I hereby grant permission for the use of any of medical records including illustration, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by the American Board of Plastic Surgery, Inc.

Patient Name_________________________________

Signature _________________________________Date_______

Photo Release

I hereby give Dr. Tanya A. Atagi and staff the absolute right and permission to copyright and/or publish, or use photographic portraits of me, or in which I may be included in whole or in part, or reproductions thereof in color or otherwise, for presentations, photo albums, display on the company's web site, art trade, news or any other lawful purpose whatsoever. I hereby waive any right that I may have to inspect and/or approve the finished product or the advertising copy that may be used in connection therewith, or the use to which it may be applied.

Patient Name __________________________________

Signature __________________________________Date______________

Patient request for restricted use for:

☐ Website / Social Media ☐ Photo Albums (in office) ☐ Talk with other patients

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Parent or guardian of a minor

I, the undersigned, being the parent or guardian of ____________________ do hereby consent and/or release photos for the stated purpose above, and signature thereto.

Patient Name _______________________________

Signature ______________________________ Date __________________

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