

Robinson Facial Plastic Surgery

Photograph Consent Form

Patient's Name: _____ Date: _____

In connection with the medical/cosmetic services which I am receiving at Robinson Facial Plastic Surgery, I consent that clinical photographs may be taken of me under the following conditions.

1. The photographs may be taken only with the consent of the nurse or physician under such conditions and at such times as may be approved by them.
2. The photographs shall be taken by a staff member approved by supervising physician/nurse.
3. The photographs shall be used for medical record purposes and shall remain the property of Robinson Facial Plastic Surgery.
4. If in the judgment of my Physician/Nurse that medical research, education or science will be benefited by their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose including advertising that my physician may deem proper in the interest of medical education, knowledge, or research provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name.
5. I the undersigned do hereby assign to you absolutely the copyright and/or the right to copyright such photography and the right of reproduction thereof, either wholly or in part, and the unrestricted use thereof in whatever manner you or your licensees or assignees may, in you or their absolute discretion, think fit for all or any advertising, medical teachings, or other purposes whatsoever, including the right necessary retouching and tinting or workup for reproduction purposes.

Patient's Name: _____

Patient's Signature: _____ **Date:** _____

I request prior permission for use of photographs other than for medical records.

(Patient's signature) _____