PHOTOGRAPHS / FILMS / VIDEO Patient # ___________

I, ________________________________, hereby authorize the Austin-Weston Center for Cosmetic Surgery and ___________________________________M.D., to use the before and after photos, film or video for the following purposes:

Patient's
Initials

_____ Teaching purposes, which include illustrating techniques to other plastic surgeons

_____ Illustrating results to prospective patients in the office or at informational talks/seminars.

_____ Advertisements of the above-mentioned physician(s), including but not limited to magazines and newspapers such as Washington Post, Washingtonian, New Beauty, Fairfax Times, etc.

_____ Place my photo, film or video on his/her professional web site and/or website directories.

I am aware that my name will not be disclosed for any of the above uses.

I certify that I have read and understand this agreement and the details of the photographing / filming / videotaping have been explained to me in terms I understand, all questions answered to my satisfaction.

I understand that there is no expiration to this authorization; however, I may revoke this authorization at any time by notifying AWC in writing. However, I understand that my revocation will not affect any actions taken by AWC prior to receiving my written revocation.

_______________________________ __________ ______________________
Patient or Legal Representative Signature Date Relationship (self, parent, etc.)

_______________________________ ____________________ __________
Print Patient or Legal Representative Name Witness Signature Date

I certify that I have explained the nature and purpose for the proposed photographs/film/videos to the patient or the patient's legal representative. I have answered all questions fully, and I believe that the patient / legal representative fully understands what I have explained.

____________________ ___________
AWC Signature Date

_____ copy given to patient

_____ original placed in chart

I was referred to the Austin-Weston Center for Cosmetic Surgery by Doctor ________________________.
I hereby authorize the Austin-Weston Center to send copies of my before and after photos, along with a description of the procedures performed, to my referring physician and/or the referring physician's office.

_______________________________ __________
Patient or Legal Representative Signature Date

.