PHOTOGRAPH RELEASE AND CONSENT

I authorize for perpetuity the use of my photographs, videotapes and case information in the following commercial/educational settings: My surgeon's office patient education materials; my surgeon's file of pre- and postoperative patient photographs available to prospective patients for viewing in the office; newspaper and magazine articles in which my surgeon participates; television programs in which my surgeon participates; and my surgeon's personal website or websites; design websites or pages; and lectures and multimedia presentations given by my surgeon for the general public.

I release and discharge Dr. Azar and all parties acting under his license and authority from all rights I may have in the photographs and 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 also authorize for perpetuity my surgeon's professional associations to use my photographs and case information in fulfilling its mission of public education, in any of the following settings; Patient education brochures available for purchase; education videotapes available for purchase; lectures and slide presentations available for purchase; information submitted by professional associations to consumer periodicals and magazines for publication; television programs about plastic surgery; cases that he has presented on the websites designated by my surgeon. I understand and accept that I may be recognized for my likeness or case history. Nevertheless, I authorize for perpetuity Dr. Azar and/or his representative to use my photographs, videotapes and case information in educational and scientific settings including lectures and multimedia presentations for an office of medical professions at which members of the press may be present, and medical, surgical and scientific journal articles.

PLEASE CHECK ONE:

☐ **I grant this consent as a voluntary contribution and certify that I have read the above authorization and release and fully understand its terms. I am authorizing use of my medical photographs as described above.**

☐ **I decline to have photographs shown for any and all above uses.**

_____ _____

Patient's Signature **Date**

_____ _____

Witness' Signature **Date**