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PLASTIC SURGERY CENTER OF THE SOUTH

AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS, INC.

PHOTOGRAPHIC CONSENT

I hereby voluntarily grant permission to Plastic Surgery Center of the South and their designated employees, to take and use any preoperative, intraoperative photos of myself for purposes of record, research, education and medical publication, as well as assisting others in making their surgical decisions. Any one of these uses can be eliminated from this form. I further understand that no form of compensation shall become payable to me for the use of these photographs.

_____ _____

Patient Signature Date

I hereby certify that I am a parent, or the person legally appointed as the guardian of the above patient, a minor person, and that I also hereby provide authorization and grant the releases described above in this document.

_____ _____

Parent/Legal Guardian Signature Date

I do not grant permission to use my photos for any reason other than for my medical record.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date