



ATLANTA PLASTIC SURGERY, P.C.

Members, The American Society of Plastic Surgeons

Date \_\_\_\_\_

Dr# \_\_\_\_\_

Account # \_\_\_\_\_

Doctor \_\_\_\_\_

**Patient Photograph Release Form**

**Patient Information**

Patient's Name \_\_\_\_\_  
Last First Middle

**Photograph Consent and Release**

I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after surgery. The photographs will be taken by one of the members of the Atlanta Plastic Surgery medical staff. I hereby give my consent for Atlanta Plastic Surgery, P.C. to use the photographs under one of the following circumstances.

Please initial one of the following:

All Media

\_\_\_\_ Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Atlanta Plastic Surgery, P.C., can be used in any print or broadcast media, including, but not necessarily limited to newspapers, pamphlets, educational films, internet, and television, in order to inform the public about plastic surgery methods. Further, I release and discharge Atlanta Plastic Surgery, P.C., any employees of Atlanta Plastic Surgery, P.C., Aesthetica SurgiCenter, P.C., and the American Society of Plastic and Reconstruction Surgery; and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

Internet

\_\_\_\_ Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Atlanta Plastic Surgery, P.C., can be used on our internet website in order to inform the public about plastic surgery methods. Further, I release and discharge Atlanta Plastic Surgery, P.C., any employees of Atlanta Plastic Surgery, P.C., Aesthetica SurgiCenter, P.C., and the American Society of Plastic and Reconstruction Surgery; and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

Medical Care Only

\_\_\_\_ Photographs taken of me or parts of my body can be used solely for the purpose of my medical care with Atlanta Plastic Surgery, P.C. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at Atlanta Plastic Surgery, P.C.

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Patient: \_\_\_\_\_

Witness: \_\_\_\_\_



Date \_\_\_\_\_

Dr# \_\_\_\_\_

Account # \_\_\_\_\_

Doctor \_\_\_\_\_

Patient Video Image Release Form

Patient Information

Patient's Name \_\_\_\_\_

Last

First

Middle

Video Image Consent and Release. Please initial the following two statements certifying that you understand and agree with each statement.

I hereby acknowledge that the video imaging procedure has been fully explained to me. In the course of consultation and discussions with employees and doctors of Atlanta Plastic Surgery, P.C., I may have been shown, or may be shown or provided certain brochures, pictures of actual patients or pictures on an electronic computer imaging device. I understand that such pictures and the alteration of these pictures are provided solely for the purpose of illustration, discussion and to improve communication between me and the doctor. I understand that the outcome of any surgical procedure is directly related to my individual characteristics and health. I further understand and acknowledge that because of the significant differences in how living tissues react to surgery, there may be no relationship between the electronic images created, and my actual final surgical result and appearance. The video images will be taken by one of the members of the Atlanta Plastic Surgery medical staff.

I understand that there is no warranty, expressed or implied, as to my final appearance after surgery by the use of these electronically altered images. There is no guarantee or assurance that my final appearance after surgery will resemble the electronically altered images provided for my review.

Please initial one of the following:

All Media

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Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Patient: \_\_\_\_\_

Witness: \_\_\_\_\_