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PATIENT PHOTOGRAPHY AUTHORIZATION AND RELEASE

The use of photographs is essential to the planning and evaluation of cosmetic and reconstructive surgery. Your surgical procedure will be photographically documented before, during and after the procedure. These photographs are a permanent part of your medical record and will never be shown to anyone without your consent.

I, ____, (please check one of the following boxes)
[ ] authorize [ ] do not authorize Tehrani Plastic Surgery and/or Dr. Ali Tehrani, and/or their representative(s), to use images of my procedure, without compensation to me, to be used in the office, on websites owned by or operated on behalf of Tehrani Plastic Surgery and/or Dr. Ali Tehrani, in print advertisements, medical presentations, articles and on television. I understand that:

1. Such photographs, slides or videotapes may be published by Tehrani Plastic surgery and/or Dr. Ali Tehrani in any print, visual or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses and internet websites, for the purpose of informing the medical profession or the general public about plastic and reconstructive methods.
2. I will not be identified by name in any of the media described above; however, I also understand that in some circumstances the photographs, slides or videotapes may display features that may identify me.
3. I have the right to revoke this authorization in writing at any time and if I decided to do so, I must present my written revocation to Tehrani Plastic Surgery. A revocation shall not affect any release of information made prior to revocation in reliance upon this authorization.

I release and discharge Tehrani Plastic Surgery and/or Dr. Ali Tehrani from all photographic liability including:

Any and all rights that I may have or may have had in the photograph, slides or videotapes of me that I have authorized to be used and disclosed in this authorization; and any claim that I may have had relating to such use and disclosure of those photographs, slides or videotapes of me, including any claim for payment in connection with any distribution or publication of them in any medium.

This Authorization is made as a voluntary contribution in the interest of public education and I certify that I have read this Authorization and Release carefully and fully understand its terms.

[ ] Patient is a minor, _______ years of age, and we, the undersigned, are the parents or guardian of the patient and do hereby consent for the patient.

____ ____________________
Patient/Guardian Signature Date

____
Patient/Guardian Printed Name