PATIENT PHOTOGRAPH CONSENT

Photographs are considered to be an integral part of your plastic surgical care. Photographs are required and nearly always taken prior to and after any procedure. Photographs may also be taken during procedures as deemed warranted. This is a generally accepted practice amongst plastic surgeons. Photographs are useful as a patient educational tool, are a critical part of surgical planning, and are a means to accurately assess results.

All photographs will be taken with as much discretion as possible. Care will be taken to assure they are as least identifiable as possible. Since the photos will concentrate on the area of concern, few will include the face. Your name will not be in the photograph. Your name will accompany the photos in storage. If the procedure includes the face, there will be NO ability to make the photos completely anonymous. Unique identifying, non-removable, body adornment such as tattoos or piercings may also preclude anonymity.

Photographs may be requested by insurance companies or others involved in your care. They may be sent through the mail, via the Internet or fax machine.

Except in an emergency, if a patient refuses to consent for photographs, Dr. Clanton may choose not to proceed with the procedure.

Please indicate which photograph consent you agree to, by placing your initials where indicated and providing your full signature below.

_____ ALL MEDIA USE
I hereby authorize, Dr. Elizabeth Clanton and/or her assistants to take, develop, utilize, and store photographs of myself. I understand that copies of these photographs may be used for professional medical purposes deemed appropriate, including, but not limited to: any print or broadcast media, patient education, medical education, surgical planning, office photo albums, internet, practice website, television, advertising media, commercial media, social media, lay publication or during lectures to medical or lay groups. I release and discharge Dr. Clanton and her staff from any and all claims or actions that I have or may have relating to such use and publications. I understand that I will not be entitled to monetary payment or any other consideration as a result of the use of these images and that these photographs will use discretion and be as confidential as possible.

_____MEDICAL USE ONLY
I hereby authorize, Dr. Elizabeth Clanton and/or her assistants to take, develop, utilize, and store photographs of myself, solely for the purpose of medical care and to request authorization for surgical procedures with my insurance company, if applicable. I understand that I will not be entitled to monetary payment or any other consideration as a result of the use of these images and that these photographs will use discretion and be as confidential as possible.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date:_____

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