PLASTIC &
RECONSTRUCTIVE
SURGERY

CONSENT TO TAKING OF PHOTOGRAPHS

In connection with the medical services which I am receiving from my physician, Dr. Elizabeth Kerner, I consent that photographs may be taken of me or parts of my body, under the following conditions:

1. The photographs may be taken only with the consent of my physician and under such conditions and at such time as may be approved by her.

2. The photographs shall be taken by my physician or a photographer approved by my physician.

3. The photographs shall be used for medical records and if in the judgment of my physician, medical research, education or science will be benefitted by their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose which she may deem proper in the interest of medical education, knowledge, or research; provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name and a separate written consent is required.

____
Patient's Name (please print)

____
Signature of Patient or Legal Guardian

____
Date

____
Signature of Witness