



EAST LAKE  
PLASTIC SURGERY CENTER

**CONSENT FOR TAKING AND/OR PUBLISHING PHOTOGRAPHS**

Patient Name: \_\_\_\_\_ Account. #: \_\_\_\_\_

I hereby grant authority to ISIDOROS MORAITIS, M.D. and/or his designated representatives to take photographs of myself/my child with the understanding that such photographs are for confidential clinical purposes of evaluation and treatment, and that all photographs remain the property of ISIDOROS MORAITIS, M.D.. I understand that the photographs are a permanent part of my medical record, and as such may be submitted to my insurance for the specific purpose of obtaining reimbursement for authorized services. I understand that the photographs may also be used for the purpose of certification of Isidoros Moraitis, M.D. by the American Board of Plastic Surgery.

Signed: \_\_\_\_\_ Print: \_\_\_\_\_ Date: \_\_\_\_\_

Office Witness: \_\_\_\_\_ Print: \_\_\_\_\_ Date: \_\_\_\_\_

**IN ADDITION** to use of these photographs for the purposes as previously stated, I consent to their use as specifically indicated below **(please check appropriate boxes to indicate approved choices):**

**YES**       **NO**

My/my child's photographs may be used for the purpose of education or science, and as such may be published and republished with appropriate documentation in professional journals or medical books, or used for any other purpose which may be deemed proper in the interest of medical education, knowledge or research; provided however, that it is specifically understood that in such publication or use I shall not be identified by name.

**YES**       **NO**

My/my child's photographs may be used for the purpose of patient/public education, and as such may be viewed by others. It is specifically understood that in such use of these photographs, I shall not be identified by name.

addendum \_\_\_\_\_  
\_\_\_\_\_

Signed: \_\_\_\_\_ Print: \_\_\_\_\_ Date: \_\_\_\_\_

Office Witness: \_\_\_\_\_ Print: \_\_\_\_\_ Date: \_\_\_\_\_