EAST LAKE
PLASTIC SURGERY CENTER

CONSENT FOR TAKING AND/OR PUBLISHING PHOTOGRAPHS

This consent and release is executed on _____, 2003 by _____(your name) in connection with the medical services which I/ my child (please circle appropriate identifier) am receiving from ISIDOROS MORAITIS, M.D. at East Lake Plastic Surgery Center.

I hereby grant authority to ISIDOROS MORAITIS, M.D. and/or his designated representatives to take photographs of myself/ my child (please circle appropriate identifier) 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 said 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 said photographs may also be used for the purpose of certification of Isidoros Moraitis, M.D. by the American Board of Plastic Surgery.

Patient/Legal Guardian Signature	Print Name **and** Relation to Patient	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**

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**

Photographs may be used for the purpose of patient/public education, and as such may be viewed by others as "before and after" photographs in the clinical setting. (i.e. photographs displayed in an album for potential clients to view during a cosmetic consultation) It is specifically understood that in such use of these photographs, I shall not be identified by name.

❒ addendum _____

_____

□ **YES** □ **NO**

Photographs may be used for the purpose of patient/public education, and as such may be viewed by others as patient "before and after" photographs on our medical office website. It is specifically understood that in such use of these photographs, I shall not be identified by name.

❒ addendum _____

_____

Patient/Legal Guardian Signature	Print Name **and** Relation to Patient	Date
Witness Signature	Print Name	Date