Patient Name:_____

BREAST BODY BEAUTY
PLASTIC & RECONSTRUCTIVE SURGERY

Authorization for and Release of Medical Photographs/Slides and/or Videotapes

INSTRUCTIONS

This is a consent document that has been prepared to help inform you concerning permission to take photographs, slides, and/or videotapes and to use these images for a purpose as defined within this consent document. It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by your plastic surgeon.

INTRODUCTION

Medical photographs/slides and videotapes may be taken before, during, or after a surgical procedure or treatment. Consent is required to take such images. Additionally, patients may consent to release these medical photography/slides, and videotapes for a stated purpose.

1. CONSENT TO TAKE PHOTOGRAPHYS/SLIDES/VIDEOTAPES

I hereby grant Breast Body Beauty Plastic & Reconstructive Surgery (Aisha J. McKnight-Baron, M.D.), and their associates or licensees permission to take pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes. I additionally consent to the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

The Board requires that all identifiable characteristics, with the exception of a full face photograph or photograph of a uniquely identifiable characteristic, be blanked out for submission of materials for the Oral Examination of The American Board of Plastic Surgery to protect patient privacy.

Patient Signature_____ **Date**_____

Witness Signature_____ **Date**_____

2. CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize Breast Body Beauty Plastic & Reconstructive Surgery (Aisha J. McKnight-Baron, M.D.), and their associates or licensees to use pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes for professional medical purposes deemed appropriate including but not limited to showing these images on public or commercial television, electronic digital networks (Internet), social media pages, for purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups. All identifiable characteristics, with the exception of a full face photograph or photograph of a uniquely identifiable characteristic, will be blacked out or concealed. I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images. All identifiable characteristics, with the exception of a full face photograph or photograph of a uniquely identifiable characteristic, will attempt to be blanked out prior to release.

Patient Signature_____ **Date**_____

Witness Signature_____ **Date**_____