meridian
PLASTIC SURGERY

PATIENT PHOTOGRAPH RELEASE FORM

Patient Name: _____ Date of Birth: _____
Last First Middle

I hereby acknowledge that I have been advised that photographs may be taken of me or parts of my body before and after surgery. The photographs will be taken by one of the members of the Meridian Plastic Surgery medical staff.

Please initial acknowledgement of the following:

_____**Medical Care Only:** Photographs taken of me or parts of my body will be used solely for the purpose of my medical care with Meridian Plastic Surgery. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at Meridian Plastic Surgery.

Please initial if you agree to use of photographs for the following purposes:

_____**Website:** Photographs taken of me or parts of my body can be used on the company's website as "Before and After" photos. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name or any other identifying marks at any time during any use or publication of these materials.

By signing this form, I acknowledge my consent as initialed above, and I further recognize that this consent form will supersede any other photo consent forms with a date prior to the date written below. This consent may be revoked at any time by written request or by completion of a new form,

_____

Signature (Patient or Parent/Guardian if Patient is under 18) Date