CHARLESTON OCULOFACIAL
PLASTIC SURGERY

Patient Photograph Consent and Release Form

Patient Name: ____
DOB: ____________

Photograph Consent and Release

I hereby acknowledge that I have been advised that photographs or videos may be taken of me before, during, or after surgery. The photographs will be taken by Dr. Rakesh Patel or one of the staff members. Sharing your results can be quite helpful for prospective patients to better understand what to expect with a given procedure. I hereby give consent for Dr. Rakesh Patel to use photographs under one of the following circumstances:

Please initial one of the following:

______ **Website**: Photographs or videos of myself as well as details of my medical services may be used on Dr. Rakesh Patel's website in order to educate the public about plastic surgery methods.

______ **Social Media**: Photographs or videos of myself as well as details of my medical services may be used on social media to educate the public about plastic surgery methods.

______ **All Media**: Photographs or videos of myself as well as details of my medical services may be used in any print or broadcast media including but not limited to newspapers, pamphlets, educational films, internet including social media, and television in order to educate the public about plastic surgery methods.

I release and discharge Dr. Rakesh Patel and all parties acting under or on behalf of their license and authority from any and all claims or actions that I have or may have relating to such use and publication and all rights, if any, that I may have in such photographs or videos and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education and *my name will not be identified.*

I give permission for:

______ Full face photographs/videos

______ Photos/videos only of limited areas on the face (eyes, lips, nose, etc.)

______ Intraoperative photographs/videos

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 new form. I understand that my revocation of this release will apply to future uses of my photographs/video and does not include any use, publication or distribution that has already occurred.

Patient Signature: ____

Date: ____