Syracuse Plastic Surgery

AUTHORIZATION FOR BEFORE & AFTER PHOTOGRAPHY

I hereby authorize Syracuse Plastic Surgery staff to take my preoperative and postoperative photos for my medical record. I understand that the use of photographs is essential to the planning and evaluation of cosmetic or reconstructive surgery. These photographs are a permanent part of your medical record and will never be shown to anyone else without your consent.

_____

Patient's Printed Name

_____

Patient or Parent/Guardian Signature

_____

Date

AUTHORIZATION FOR USE OF PHOTOS

For various reasons Syracuse Plastic Surgery staff shows and or uses before and after photographs of patients. I hereby authorize Syracuse Plastic Surgery to use my before and after photographs for any educational and marketing purposes. Syracuse Plastic Surgery agrees to exercise respect for your privacy when utilizing photographs.

_____

Patient's Printed Name

_____

Patient or Parent/Guardian Signature

_____

Date