



Patient consent for medical photography and/or videography

AUTHORIZATION

I authorize the use and disclosure of my photographs, videos, and testimonials for the following: medical education, marketing, websites, and social media by **IDEAL PLASTIC SURGERY**.

I would like to **EXCLUDE** the following:

Name Face Other: _____

I authorize the use and disclosure of my photographs **SOLELY** for the purpose of my medical care with **IDEAL PLASTIC SURGERY**.

REVOCABILITY

I understand that I may revoke this authorization at any time, but such a revocation must be in writing and received by **IDEAL PLASTIC SURGERY**. Revocation affects disclosure moving forward and is not retroactive.

I hereby grant permission for 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.

PATIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____