CONSENT FOR RELEASE OF PHOTOGRAPHS

Photographs will be taken before and after surgery for documentation. We would like to ask your permission to use these photographs to show future patients, and *possibly* on our website gallery. This gives patients a realistic idea of the results they can expect should they choose to have a similar procedure. Rest assured that your identity is kept confidential.

Initial the following:

_____ Yes, you may use my photos to show future patients.

_____ Yes, you may use my photos to show future patients, but not the website.

_____ No, please do not use my photos.

I acknowledge that photographs may be taken of my body in connections with the medical services to be performed by my physician. I herby 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.

DISCLOSURE OF OWNERSHIP

The physicians of Pediatric Plastic Surgery Institute have developed Dallas Day Surgery Center of North Texas, Pine Creek Medical Center, Forest Park Medical Center of Frisco and The Cloister to provide a clean, safe, caring environment for our patients. While the physicians are investors in the facility, and may at times receive an investment distribution, the management directive is to provide the best possible quality of care at the most economical cost to your patients.

You are not required to have your procedure performed at these facilities. If you would prefer to have your surgery performed at another facility where your doctor has privileges, your doctor will do his/her best to accommodate you.

I have read this disclaimer and understand that I have the option of choosing an alternate facility.

Patient/Guardian Signature

Witness Signature

Date

Pediatric Plastic Surgery Institute
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