



## Authorization For Release and or Publication of Photographs

I hereby authorize the release and/or publication of photographs that may be taken pre-operatively, during surgery, or post-operatively, without limitation regarding my physical and mental condition. I consent to these photographs being available for patient viewing, teaching, and/or advertising.

Patient Name: (Please Print) \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I consent for my photographs to be used for **teaching purposes only.**

Patient Name: (Please Print) \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Physician Only:** I confirm with my signature that I have made time available to discuss with the above-named patient the risks, potential complications, and intended benefits of surgery. The patient has had the opportunity to ask any questions, all questions have been answered, and the patient has expressed understanding. Thus informed, the patient has requested to perform surgery on him/her.

Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_

Our patients are offered a copy of any form they sign