DIBELLO
PLASTIC SURGERY

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AUTHORIZATION FOR AND RELEASE OF MEDICAL PHOTOGRAPHS

INSTRUCTIONS

This is a consent document that has been prepared to help inform you concerning permission to take photographs, and to use these images for a purpose as defined within this consent document. Medical photographs may be taken before, during, or after a surgical procedure or treatment. Consent is required to take such images. Additionally, patients may consent to release these medical photographs for a stated purpose. It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by Dr. DiBello.

1. CONSENT TO TAKE PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize Joseph N. DiBello, MD and/or his associates or licensees to take pre-operative, intra-operative, and post-operative photographs of me, or parts of my body, associated with the plastic surgery procedure(s) intended or performed as a routine part of my professional medical care. I understand that photographs will be kept strictly confidential, and neither I, nor any member of my family, will be identified by name. I understand, however, that in some circumstances the photographs may portray features which shall make my identity recognizable.

2. CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPES

Additionally, I hereby authorize Joseph N. DiBello, MD and/or his associates or licensees to use the pre-operative, intra-operative, and post-operative photographs taken of me for professional medical purposes in the formats listed below. I understand that I will never be identified by name in any use of these photographs, but in some circumstances the photographs may portray features that make my identity recognizable.

Please initial YES or NO for each of the items below

____ YES ____ NO For our **office photo gallery** to help future patients understand and see outcomes from surgery with Dr. DiBello.

____ YES ____ NO On our **Practice Website and/or Affiliated Websites** for prospective patients to see and understand outcomes form surgery with Dr. DiBello.

I release and discharge Dr. DiBello/DiBello Plastic Surgery from all rights that I may have, monetary or otherwise, in the photographs and from any claim I may have relating to such use in publication or distribution. I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

_____ _____

Patient Date

_____ _____

Witness/DPS Staff Date

I have read the above Authorization and Release. I am the parent, guardian or conservator of _____, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

_____ _____

Parent/Guardian Date