

PACES PLASTIC SURGERY AND RECOVERY CENTER
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PHOTOGRAPHIC CONSENT

I hereby voluntarily grant permission to Paces and Paces North Plastic Surgery Center and/or their designated employees to take and use any pre-operative, intra-operative, or post-operative photos of myself for purposes of record, research, education, and medical publication, as well as assisting others in making their surgical decisions. Any of these uses may be eliminated from this form.

I further understand that no form of compensation shall become payable to me for the use of these photographs.

I hereby release Paces Plastic Surgery Center and its agents from any and all claims and demands arising out of or in conjunction with the use of these photographs.

Signature

Date

Print Name

I hereby certify that I am a parent or the person legally responsible as the guardian of the above patient, a minor person, and that I also hereby provide authorization and grant the releases described above in this document.

Parent/Legal Guardian Signature

Date

Print Name

