

PATIENT CONSENT FOR PHOTOGRAPHY

I hereby give my consent to JOSEPH Advanced Facial Plastic Surgery, PLLC (DBA JOSEPH Advanced Oculofacial Plastic Surgery). or its affiliates to take photographs of me in connection with my care.

I understand the photographs, audio/video/interviews taken for educational or publicity purposes may be published in print, visual or electronic media, specifically including, but not limited to, publications, scientific presentations, and internet websites including placement on the JOSEPH Advanced Facial Plastic Surgery, PLLC (DBA JOSEPH Advanced Oculofacial Plastic Surgery) web site for the purpose of informing the medical profession or the general public about plastic surgery methods, results, issues, trends, and similar matters. I will not be identified by name in any publication. I understand that in some circumstances, the photographs/audio/video interviews may contain features which shall make my identity recognizable. I hereby waive all rights that I may have to any claims for payment or royalties in connection with the use of these photographs, audiotapes, videotapes and interviews, and agree that these shall at all times be property of JOSEPH Advanced Facial Plastic Surgery, PLLC (DBA JOSEPH Advanced Oculofacial Plastic Surgery) or the media representative present.

I further understand that I have the right to withdraw this authorization at any time in writing to the appropriate person except to the extent that action has already been taken to release this information. JOSEPH Advanced Facial Plastic Surgery, PLLC (DBA JOSEPH Advanced Oculofacial Plastic Surgery) will not refuse to treat me based on whether I agree to allow my imaging records to be used or disclosed.

I hereby release JOSEPH Advanced Facial Plastic Surgery, PLLC (DBA JOSEPH Advanced Oculofacial Plastic Surgery) or any of its affiliates, employees or agents from all liability, including any claims for libel or invasion of privacy, directly or indirectly connected with, arising out of, or resulting from, the taking and authorized use of these photographs, audiotapes, videotapes and interviews.

I hereby warrant that I am over eighteen years of age, and competent to contract in my own name.

By electronically signing, I grant this consent voluntarily and certify that I have read the above Authorization, Release, and Discharge and fully understand its terms.

Signature of Patient/Legal Representative

Date