

East End Plastic Surgery & Laser Center
Judy Ann Emanuele, M.D., F.A.C.S.

Authorization for Photographs

Many of the procedures, which Dr. Emanuele performs, require the taking of photographs. It is important that you read this information carefully and completely. After reviewing, please sign below.

- ❖ I hereby authorize Dr Emanuele to take photographs (slides, prints, or digital) of me for review by my insurance company, to determine reimbursement.

- ❖ I authorize the use my photos for medical purposes and review by prospective patients and other interested persons.

- ❖ I understand that my identity will remain confidential unless I specify otherwise and that these photos will be part of my legal medical record.

I specifically do / do not authorize the use of my photos on the East End Plastic Surgery & Laser Center web site. *Initial*_____ **Please check box and initial.**

I specifically do / do not authorize East End Plastic Surgery & Laser Center to use my photos for promotional use. *Initial*_____ **Please check box and initial.**

I hereby release all involved parties from all legal responsibility or liabilities that may arise from the taking or use of these photographs.

Patient/Responsible Party Signature

Date

Relationship to patient: _____ (Please complete if patient is a minor [under 18 years of age] or otherwise unable to give consent for photographs.)

Witness Signature

Date