

East End Plastic, Reconstructive, & Hand Surgery, P.C.  
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. Please read the following and 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 purpose only and understand that my identity will remain confidential unless I specify otherwise.
- I understand that the photos will be part of my medical records

I hereby release all involved parties from all legal responsibility or liabilities that may arise form 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