

***Photo Release Authorization***

I, \_\_\_\_\_, authorize Michael C. Glafkides, M.D., and/or such assistants as may be assigned by him to take photographs as he deems appropriate.

I understand that photography is important in planning and evaluating surgery, and I agree to allow the use of my pre-operative and post-operative photographs for:

- Publications and Lectures for Educational Purposes*
- Presentations to Audiences Comprised of Medical and Lay Persons*
- Web Site Accessible Through the Internet*

*I understand that my name will be kept confidential. Photos of my face may be used only if surgery on my face was performed. I also understand that I will not be entitled to any payment or compensation as a result of the use of these photographs.*

*I understand that I have the right to revoke this authorization at any time. This request must be in writing.*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Procedure(s):** \_\_\_\_\_

**Expiration Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**a/o 10/28/2011**