ROBERT J. SPIES, M.D.

AESTHETIC AND RECONSTRUCTIVE PLASTIC SURGERY

PERMISSION FOR PHOTOGRAPHY

Name _____

I consent to the taking of photographs by Dr. Robert Spies or his designated representative of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Robert Spies. I understand that these photographs are for confidential, clinical records purposes and that all photographs remain the property of Dr. Spies.

Occasionally, such photographs are used for teaching purposes, medical and/or public education and patient information. These photographs may be placed in photograph books that Dr. Spies and his staff show to new patients as part of patient education. These photographs may also be chosen by Dr. Spies to be used on his web site for patient education purposes. If any photographs are used for these purposes, I will not be identified by name. I understand that in some circumstances the photographs may portray features that will make my identity recognizable.

I understand that I may refuse to authorize the release my photographs for such purposes and that my refusal will prevent the disclosure of such information, but will not affect the health care services I presently receive or will receive from Dr. Spies.
I understand that I have the right to inspect and copy the photographs that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation.
I release and discharge Dr. Spies and all parties acting under his license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use including any claim for payment in connection with the use of these photographs.
I certify that I have read the above Permission for Photography and fully understand its terms.

I will _____ permit the use of my photographs for such ethical professional purposes.
I will not _____ permit the use of my photographs for such ethical professional purposes.
(Please Initial One)

_____ _____
Signature (patient or responsible party) **Date**

_____ _____
Witness **Date**