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**PATIENT PHOTOGRAPHIC CONSENT AND RELEASE**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_consent to the taking of photograph by Dr. Derrick Gale or his designee, of me or parts of my body in connection with the plastic/ reconstructive surgery or skin care procedures to be performed.

I understand that such photographs may be published in any print, visual or the internet, specifically including but not limited to: Medical journals and text books for the purpose of informing the medial profession or the general public about plastic & reconstructive surgery methods.

Neither I, not any member of my family will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that shall make my identity recognizable.

I release and discharge Dr. Gale and associates and all parties acting under their license and authority form all rights that I may have in such photographs and from any claim that I may have relating to such use in publication including any claim for payment in connection with distribution or publication of photographs.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above consent and release and fully understand its terms.

I give my consent that my photographs or likeness may be used for marketing purposes including use on the internet, photo galleries, social media, etc.

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Signature Date

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Witness/ Physician Date

I have read the above consent and release. I am the parent, guardian, or conservator of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a minor. I am authorized to sign his consent on her/his behalf and grant this consent as a voluntary contribution in the interest of public education.

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Parent/Guardian Date