Patient's Consent to be Photographed

In connection with the medical services I am receiving from Dr. Scheiner, I consent that photographs may be taken of me or parts of my body, under the following conditions:

1.) The photographs may be taken only with the consent of my physician and under such conditions and at such times as may be approved by him.

2.) The photographs shall be taken by my physician or by a photographer or staff member approved by my physician.

3.) The photographs shall be used for medical records. If in the judgment of my physician, medical research, education or science will benefit by their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose which may deem proper in the interest of medical education, knowledge, or research, provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name.

4.) I hereby grant permission for the use of any of my medical records including illustrations, photographs, or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

Patient's Name______________________________

Signature __________________________________ Date ______________________

Witness ___________________________________