Photography Consent

Michael E. Decherd, MD, FACS

I, _____, consent to the taking of photographs by San Antonio Plastic Surgery Institute (Michael E. Decherd, MD) or designee of me or parts of my body in connection with the plastic surgery procedure(s) intended or performed. I understand that photographs may be taken before, during, and after my procedure(s) as a routine part of my medical care. I further understand that these photographs will be kept strictly confidential.

Signature:_____ Date:_____

Release of Photographs Consent

Additionally, I authorize the use of my photographs in the formats listed below. I waive any right to inspect or approve the finished product, advertising, or other copy that may be used in connection with the options below. I understand that I will **never** be identified by name in any use of these photographs, but that in some circumstances the photographs may portray features which make my identity recognizable.

(Please initial YES or NO for each of the items below)

_____ YES _____ NO For our **office photo gallery** to help future patients understand and see outcomes from surgery with Dr. Michael Decherd.

_____ YES _____ NO On our **website or affiliated websites** for prospective patients to see and understand outcomes from surgery with Dr. Michael Decherd.

I release and discharge Dr. Michael Decherd from all rights that I may have in the 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 the photographs.

I certify that I have read the above Authorization and Release and fully understand its terms.

Print Name: _____ Date:_____

Signature:_____ Witness: _____

This consent may be revoked at any time with a written consent.