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PHOTOGRAPHIC RELEASE AND CONSENT

I, _____, agree that Roberta L. Gartside M.D. or designated representatives or the practice may take and use preoperative and postoperative photographs of my person for confidential clinical record purposes, and that such photographs shall remain the property of Roberta L. Gartside M.D.

Patient Signature _____ Date _____

The below additional consents are voluntary by patient preference:

I fully and specifically grant my permission for the use of photographs, videotapes or case information for the following additional purposes as indicated by my initials below. As a result of this use I understand that these photographs, videotapes or case information may appear in other related, updated or reprinted formats at any concurrent or future occasion. I understand that such consent is strictly on a voluntary basis. I understand a copy of this consent may be supplied with the images to any third party wherein they may be published or presented. I understand that some photographs may, by their representation make me identifiable in appearance to others. I authorize Roberta L. Gartside M.D. to use my photographs, videotapes, and case information in the following educational and scientific settings that I have initialed:

_____ My surgeon's office for patient education materials

_____ My surgeon's file of pre and post operative patient photographs available to prospective patients for viewing in the office

_____ Newspaper and magazine articles in which my surgeon participates

_____ Television programs in which my surgeon participates

My surgeon's personal web site or web page, social media sites

_____ ___ Photo only ___ Photo and First name only

Lectures and multimedia presentations given by my surgeon for the general public

_____

Signature of Patient or Personal Representative _____ Date _____

Printed Name of Patient or Personal Representative _____ Relationship of Personal Representative to the Patient _____

Signature of Practice Representative and Witness _____