



WFDCDTINC135

PHOTOGRAPHY AUTHORIZATION

BEACHWOOD PLASTIC SURGERY & MEDICAL SPA

3609 Park East Drive, Suite 206

Beachwood, OH 44122

Because plastic surgery is a visual specialty there are many situations where photographs are used. Be assured that Dr. Goldman and his staff treat every patient with dignity and have the utmost respect for your privacy. If you have any questions for us regarding the use of photography please feel free to consult with Dr. Goldman before signing this form.

Authorization for Photography:

I, _____, understand that, as part of my **medical record**, photographs may be requested to document my condition both before and after treatment or surgery. I grant permission to be photographed and understand that these photos may be used for submission to my insurance company as needed and/or to confidentially educate other patients.

initials _____

I, _____, further consent to the use of my images in photographs for the purpose of **publication** in scientific publications, medical journals or for use at scientific meetings.

initials _____

I, _____, further consent to the use of my images in photographs for the purpose of publication and display on the **website(s)** of Beachwood Plastic Surgery & Medical Spa.

initials _____

I, _____, further consent to the use of my images in photographs for the purpose of publication and display in print or television **advertising** by Beachwood Plastic Surgery & Medical Spa.

initials _____

I, the undersigned, authorize photography use as directed above by my initials. I further understand that this authorization can be revoked at any time by forwarding directives, in writing, to the above address.

Signature: _____ Social Security #: _____ Date: _____