Restifo Plastic Surgery
PLASTIC & RECONSTRUCTIVE SURGERY
Richard J. Restifo, MD Johnny C. Mao, MD P:203.772.1444 F: 203.907.0503

Consent for Taking Photographs

Patient Name (Printed): _____ Date: _____

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

Initials

_____ 1. My physician/physician assistant/LPN shall take the photographs. Images will not include my face.

_____ 2. The photographs shall be used for medical records, and, if in the judgement of my physician, may be sent to my insurance carrier should the carrier need such photographs and information relating to my case.

_____ 3. The photographs may be used for medical lectures and/or consultations at the discretion of my physician.

_____ 4. The photographs may be used in print publications and/or online for the purposes of patient education and marketing.

_____ 5. I will not be identified by name in any publication.

I agree and authorize the use of my photos as outlined in the terms which I initialed above. I have been provided the opportunity to ask questions concerning medical photography and understand that refusal to consent will not affect my medical care.

Patient's Signature : _____
(Or signature of parent/guardian if patient is under 18 years of age)

Date: _____

Witness: _____