Las Colinas Centre for Plastic Surgery

Michael R. Whetstone, M.D.
Board Certified
Plastic & Reconstructive Surgery
Cosmetic Surgery

American Society of
Plastic Surgeons, Inc.

Patient Photographic Authorization & Release

In the course of consultation and discussions with certified medical professionals, I may have been shown, or may be shown or provided certain brochures, pictures of actual patients or pictures on an electronic computer imaging system. I do understand that those pictures and alteration of these pictures seen are solely for the purpose of illustration, discussion and to provide improved communication with medical professionals. I do understand that the outcome of any type of surgical procedure is directly related to my individual characteristics and health. I further understand and acknowledge that because of the obvious significant differences in how living tissue reacts to surgery, there may be no relationship between the electronic images created, and my actual final surgical result. Use of the computer imaging system offers an opportunity for me to discuss my desires and to allow improved communication with the medical staff. I consent to the taking of photographs by Dr. Whetstone or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Whetstone. We will take all reasonable precautions to ensure your privacy, but be aware that even secure sites are susceptible to being hacked, and the files, although they do not have your name attached, may contain internal codes the websites plan to "scrub" or delete. We will notify you if there has been a violation from these other sources, and we will protect your privacy to the best of our ability.

I authorize Michael R. Whetstone, M.D., and associates or assistants of their choice, to take photographs of the treatment site for record purposes on _____.

Patient Name

Patient's
Initials

_____ I agree and authorize use of the photos for teaching purposes, which include being shown to other patients. *I am aware that my name and identity will not be disclosed.*

_____ ***I DO NOT*** authorize the use of these photos for teaching purposes.

_____ I agree and authorize use of the photos in selected advertisements of the above-mentioned physician. *I am aware that my name and identity will not be disclosed.*

_____ ***I DO NOT*** authorize the use of these photos for advertising.

_____ I agree and authorize the above-mentioned physician to place my photos on his professional web site. *I am aware that my name and identity will not be disclosed.*

_____ ***I DO NOT*** authorize the use of these photos on any web site.

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature.

_____ _____

Patient or Legal Representative Signature/Date Relationship (self, parent, etc.)

_____

Print Patient or Legal Representative Name