Plastic Surgery & Dermatology Associates (PSDA)

PERMISSION FOR PHOTOGRAPHY

I hereby voluntarily grant permission to ______________________ and his designated representatives to take and use clinical photographs of my _____________________ with the understanding that such photographs are for confidential, clinical record purposes, and that all photographs remain the property of the doctor.

______________________________ ____________
Signature Date

____
SSN

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Birthday

Occasionally, such photographs are used for teaching purposes, research, medical publications, medical, as well as public education and for patient information and education.

I will/will not (circle one) permit the use of my photographs for such ethical professional purposes.

______________________________ ____________
Signature Date

______________________________ ____________
Witness Date