MORGAN

COSMETIC SURGERY

Medical Photography Consent Form

Please cross out any part to which you do not agree.

I,_____, consent to medical images including medical photographs and/or medical video being made of myself to document my condition and treatment. I agree that the images may be provided or published (which means shown, stored and/or copied in print or digital format) to:

- a referring or referred to doctor,
- to my medical record for my education, documentation and treatment planning,
- an operating or treatment room for use during my treatment,
- to my insurance provider as needed for coverage,
- to a treating or consulting health professional,
- to health professionals for education and training,
- to non-health professionals for educational purposes or to illustrate various results,
- to Dr Elizabeth Morgan's website as part of her "Before & After" gallery to illustrate expected results.

- My agreement applies to images that do not show my face
- My agreement also applies to images that do show my face.
- I understand that only images relevant to my condition are taken.
- I understand that my name and other identifying data are disclosed only to health professionals involved in my care and to relevant insurers.
- I understand that medical images will protect my privacy and dignity to the maximum extent possible.

By signing below, I confirm that I understand this consent form and agree to the above.

_____ _____

Signature of Patient/Parent or Guardian Date

_____ _____

Signature of Witness Date