TAROLA PLASTIC SURGERY
NICHOLAS A. TAROLA, MD

Photo Release

I, _____agree that Nicholas A. Tarola, MD or designated representatives of the practice may take and use preoperative and postoperative photographs of my person for confidential clinical record purposes, and that such photographs shall remain the property of Nicholas A. Tarola, MD.

I fully and specifically grant my permission for the use of photographs, videotapes or case information for the following additional purposes as indicated by my initials below. As a result of this use I understand that these photographs, videotapes or case information may appear in other related, updated or reprinted formats at any concurrent or future occasion. I understand that such consent is strictly on a voluntary basis. I understand a copy of this consent may be supplied with the images to any third party wherein they may be published or presented. I understand that some photographs may, by their representation make me identifiable in appearance to others. I authorize Nicholas A. Tarola, MD to use my photographs, videotapes, and case information in the following educational and scientific settings that I have initialed: (PLEASE CHECK)

Yes____ No____ Dr. Tarola's office patient education materials

Yes____ No____ Dr. Tarola's file of pre- and postoperative patient photographs available to prospective patients for viewing in the office

Yes____ No____ Dr. Tarola's educational websites or web pages (face/identifying features such as tattoos will not appear in photos unless surgery involves face)

Yes____ No____ Dr. Tarola's lecture and multimedia presentations for educational purposes

_____ _____
Signature of Patient or Personal Representative **Date**

_____ _____
Printed Name of Patient or Personal Representative **Relationship of Personal Representative to the Patient**

_____
Signature of Practice Representative and Witness