Lowe Plastic Surgery (LPS)

PERMISSION FOR PHOTOGRAPHY

I hereby voluntarily grant permission to ___**Dr. Lowe**____ and/or his or her designated representatives to take and use clinical photographs with the understanding that such photographs are for confidential, clinical record purposes, and that all photographs remain the property of the doctor.

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.

I will / will not (circle one) permit the use of my photographs for ethical professional purposes to include Dr. Lowe's website or other media publications. Neither I, nor any member of my family, will be identified by name. I understand that in some circumstances the photographs may portray features that will make my identity recognizable. Whenever possible these features will be concealed except in the cases of facial photographs where it would not be possible. I further understand that I have the right to revoke this authorization in writing at any time.

_____ _____
Signature Date

_____
Birthday

_____ _____
Witness Date