Sullivan Integrated Aesthetic CENTER

Plastic Surgery & Medical Spa

Dr. Kelly Sullivan

Patient Photograph Release Form

Patient Information:

Patient's Name:_____ Patient's Date of Birth:_____

Photograph Consent and Release:

I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after surgery. The photographs will be taken by one of the members of the Sullivan Integrated Aesthetic Center medical staff. Any photographs taken will become part of my medical records. My photographs are to be used for the purposes of insurance pre-authorization, office and hospital medical charts, and any necessary medical treatment.
I hereby give my consent for Sullivan Integrated Aesthetic Center to use the photographs under the following conditions:

Please choose one of the following options and initial

(Please initial) _____ I authorize my photographs to be used for the purposes of: Medical Seminars, website publication and/or office photo albums. All efforts will be made to ensure patient anonymity and confidentiality. No names or identifying references will be made in conjunction with published photography.

(Please initial) _____ I authorize my photographs to be used only for my medical record, my surgery record and insurance purposes of my surgery with Dr. Sullivan. I understand these photos *will not* be used on the office website or in any publications.

Patient's Signature: _____Date: _____

Witness's Signature: _____ Date: _____

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