MICHAEL J PACIOREK MD
Facial Plastic Surgery

Photographic Release Form

Record of Authorization for Taking and Publication of Photographs

In connection with the medical services, which I am receiving from my physician, Dr. Paciorek, I consent that photographs may be taken of me of parts of my body under the following conditions:

A. The photographs may be taken only with the consent of my physician and under such conditions and at such time as may be approved by him.

B. The photographs shall be taken by my physician or by a photographer approved by my physician.

C. The photographs shall be used for medical records and media purposes, and if it is in the judgment of Dr. Paciorek, medical research, education, or science will benefit from their use, such as photographs and information relating to my case may be published in professional journals, books, pamphlets, the office website, or any other purpose that he may deem proper in the interest of medical education, knowledge, or research; provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name.

Patient's name (PRINT): _____

Patient's signature: _____

Date: _____

If a minor or patient is unstable to affix signature: _____

Proxy/Guardian's name (PRINT): _____

Proxy/Guardian's signature: _____

Date: _____