DR GAVIN M DAVISON
orchard park aesthetics

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the art of beauty and medicine

PHOTOGRAPHY CONSENT

I, _____ , agree that Gavin M. Davison, MD or designated representatives or 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 Gavin M. Davison, MD.

Patient Name:_____ Date: _____

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 that some photographs may, by their representation make me identifiable in appearance to others. I authorize Gavin M. Davison, MD to use my photographs, videotapes, and case information in the following educational and scientific settings that I have initialed:

_____ My surgeon's office patient education materials

_____ My surgeon's file of pre- and postoperative patient photographs available to prospective patients for viewing in the office

_____ Newspaper and magazine articles in which my surgeon participates

_____ My surgeon's personal web site or web page

_____ Lectures and multimedia presentations given by my surgeon for the general public

Signature of Patient _____

Printed Name of Patient _____

Signature of Practice Representative and Witness _____