AHN POINT

WELLNESS
FACIAL PLASTIC SURGERY
AESTHETIC MEDICINE

Patient Name _____ DOB _____

## AUTHORIZATION FOR RELEASE AND PUBLICATION OF PHOTOGRAPHS

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

- The photographs may be taken only with my consent of my physician and under such conditions and at such times as may be approved by him.
- The photographs shall be taken by my physician or by a photographer approved by my physician.
- The photographs shall be used for medical records and media purposes, and if in the judgment of Dr. Ahn, medical research, education, or science will be benefited by their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals, books, pamphlets, internet or used for any other purpose which 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.

**PLEASE CHECK A BOX:**

□ **I APPROVE use of my photographs as stated above.**
□ **I DECLINE use of my photographs as stated above.**

**Patient Signature:** _____ **Date:** ____/____/_____

***If minor or patient is unstable to affix signature:***

**Proxy/Guardian Name (Print):** _____

**Proxy/Guardian Signature:** _____ **Date:** ___/____/____

**Relationship to Patient:** _____