PLASTIC SURGERY

THOMAS TREY SANDS, M.D.
PLASTIC AND RECONSTRUCTIVE SURGERY
4224 HOUMA BLVD, SUITE 120 METAIRIE, LA 70006
Telephone #: 504-888-4297 Fax #: 504-456-2502

PATIENT PHOTOGRAPH RELEASE FORM

Patient's Name_____

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 Thomas T. Sands, M.D., staff. I hereby give my consent for Thomas T. Sands, M.D. to use the photographs under one of the following circumstances:

Please initial ONE of the following:

ALL MEDIA

_____Photographs taken of me or parts of my body as well as details regarding medical services I have received by Thomas T. Sands, M.D. may be used in any print or broadcast media, including but not necessarily limited to newspapers, pamphlets, educational films, our internet site and television, in order to inform the public about plastic surgery methods. Further, I release and discharge Thomas T. Sands, M.D., the facility used and all parties acting under their license and authority from any and all claims or actions that I have or may have relating to such use and publication and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

WEBSITE ONLY

_____Photographs taken of me or parts of my body as well as details regarding medical services that I have received by Thomas T. Sands, M.D. may be used on our internet website in order to inform the public about plastic surgery methods. Further I release and discharge Thomas T. Sands, M.D., and employees of Thomas T. Sands, M.D., any facility used and all parties acting under their license and authority from any and all claims or actions that I have or may have relating to such use and publication and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public

education, and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

PHOTO ALBUM ONLY

_____Photographs taken of me or parts of my body as well as details regarding medical services that I have received by Thomas T. Sands, M.D. may be used in the photograph album in order to inform other patients of Thomas T. Sands, M.D., about plastic surgery methods. Further I release and discharge Thomas T. Sands, M.D., and employees of Thomas T. Sands, M.D., any facility used and all parties acting under their license and authority from any and all claims or actions that I have or may have relating to such use and publication and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment in connection with any such use or publication in the photograph album. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject to only the condition that I am not identified by name at any time during any use of these materials by any party.

Date_____

Witness_____

Patient or Guardian
Signature_____