



PHOTOGRAPHY AND VIDEO CONSENTS

SURGICAL DOCUMENTATION

____I have given Dr. Alinsod and his Staff full consent to take photographs or videos of my surgical procedure. This includes Pre-Op, Intra-Op, and Post-Op time periods. I understand that the photographs are strictly for documenting the surgery and evaluating the results of surgery. I understand that the digital photographs will be stored securely on Dr. Alinsod's computers and charts with full HIPPA Regulations followed.

Name

Date

Witness

Date

EDUCATIONAL AND MARKETING USES

____I give Dr. Alinsod full consent to use my photographs or videos for educational and marketing purposes (various media outlets such as print, CD/DVD, or internet) in an anonymous manner and with complete confidentiality. There will be no identifying marks seen or portrayed unless approved by me.

____I decline to have my photographs or videos used for educational or marketing purposes.

Name

Date

Witness

Date