

PHOTOGRAPHIC AUTHORIZATION

PATIENT'S NAME: _____

Authorization to use photographs as indicated below, please check all boxes as they that apply (Note that the first box must be checked to complete your medical records):

- Yes No Authorize CoZmedic Surgery Associates to use my photographs for medical purposes pertaining to this surgery
- Yes No CoZmedic Surgery Associates Before & After Photo Album
- Yes No CoZmedic Surgery Associates Internet Displays
- Yes No CoZmedic Surgery Associates related Television / Radio
- Yes No CoZmedic Surgery Associates related Magazines / Newspapers
- Yes No CoZmedic Surgery Associates to use me for referral purposes

This is to certify that I, the undersigned, give full consent to CoZmedic Surgery Associates to have photographs, motion pictures, and/or video tapes taken before, during and after my contemplated surgery as indicated above.

I authorize their use as described above and it is specifically understood that I shall not be identified by name unless described above. I waive the right to inspect and/or approve the finished product. Additionally, I waive the claim to royalties or payment in connection with these photographs and the finished product.

Patient's Signature: _____

Patient's Printed Name: _____

Witness' Signature: _____

Date: _____

Additional Notes: