

## CONSENT FOR PHOTOGRAPHS

I understand that photographs will be taken periodically throughout my treatments. These photographs will be used to monitor progress and other factors. I understand that failure to consent to these photos will give the provider (Peter J. Abramson, M.D. its successors) the right to decline my treatment.

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_

I, \_\_\_\_\_ DO

I, \_\_\_\_\_ DO NOT

grant Peter J. Abramson, M.D. and its successors and assign the right to use photographs of me, in the following areas: (initial all/any for use)

- \_\_\_\_\_ Website for Consumers
- \_\_\_\_\_ Newsletter to be sent to patients
- \_\_\_\_\_ Practice brochures
- \_\_\_\_\_ Public relations material
- \_\_\_\_\_ Seminars
- \_\_\_\_\_ Patient before and after photo information sheets

\_\_\_\_\_ Copy to patient of before and/or after photos at patient request. (This permits Peter J. Abramson, M.D. to send photos from your medical records to your primary address on file unless otherwise indicated by patient or patient's responsible party.)

I understand that by signing below, Peter J. Abramson, M.D. need not approach me again for authorization on these photos.

\_\_\_\_\_  
Patient Full Name – Please Print

\_\_\_\_\_  
Witness Full Name – Please Print

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

*Affiliated with Ear, Nose and Throat of Georgia, LLC*