Santa Barbara Plastic Surgery Center

Wesley G. Schooler, M.D., F.A.C.S.

CONSENT TO USE MY PHOTOGRAPHS

Our doctors often take pre-operative, intra-operative, and post-operative photographs of patients to provide the best care possible for you. **Photos are very useful for planning and evaluating your surgery.** In addition, photographs are an essential part of medical recordkeeping in plastic surgery. Dr. Schooler often gives lectures to patient groups and to physicians at national meetings. We have very clear guidelines for how we take these photographs and how they are stored and used. We respect your privacy and every effort will be made to avoid any views in which you can be recognized except where that may be impossible such as pictures of the face. No names or other identification will be used. Many patients, happy with their results, have given permission to use their photos anonymously.

Please consider the following circumstances and either authorize or deny use of your photos by Dr. Wesley Schooler and the staff of the Santa Barbara Plastic Surgery Center for each situation outlined below. Please initial 1-4

1. _____I, the undersigned, do hereby authorize the obtaining of photos or video and the anonymous use of my photographs/videos for planning and surgical record keeping by my doctor during any office visits, consultations, hospital or office procedures, and while under anesthesia.
   YES_____ NO_____

2. _____I, the undersigned, do hereby authorize the anonymous use of my photographs by my doctor in seminars, health fairs, and conference for interest and/or prospective patients, as well as to teach other doctors and medical personnel about Plastic Surgery in any and all media now or hereafter known, and exclusively for the purpose of patient education, physician education, research, print or electronic form publicly or privately without my name being mentioned. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used. I understand that there will be no financial of other remuneration for recording me, either for initial of subsequent transmission of playback, responsible for any expense of liability incurred as a result of my participation in this recording, including medical expenses due to any sickness or injury incurred as a result.
   YES_____ NO_____

3. _____I, the undersigned, do hereby authorize the anonymous use of my photographs by my doctor in articles written by my doctor for publication in medical journals, magazines, and/or newspapers.
   YES_____ NO_____

4. _____I, the undersigned, do hereby authorize the anonymous use of my photographs by my doctor in television interviews of my doctor or programs produced for cable T.V. or a web page.
   YES_____ NO_____

_____ _____

Patient Signature Date

Patient Name

DOB