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, during and after procedures. I release and discharge Tannan Plastic Surgery and Shruti C. Tannan, MD, its successors and assigns, and all parties acting under its 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 that I may have in such information, photographs, electronic images, video footage and details ("Media") regarding medical services rendered me, including claim for payment in connection with any such user or publication.

I hereby give my consent for Tannan Plastic Surgery to use the Media for the purposes of my medical care with Tannan Plastic Surgery and for in-office photograph albums, print media, broadcast media and electronic media. My consent is subject to the condition that I am not identified by name at any time during any use or publication of these materials.

I certify that I have read the above authorization and release and fully understand its terms.

Patient Signature_____ Date_____

Witness Signature_____

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