**CONSENT AND RELEASE FOR PHOTOS**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby consent to the use of photographs taken of me by the office of Anthony Echo, M.D. for the purpose of education, training and surgical planning. I understand that I shall not be identified by name and every effort will be made to remove or limit identifiable features when possible.

**Please initial your acknowledgement:**

\_\_\_\_\_\_\_ I hereby release Anthony Echo, M.D., his personnel and any other persons participating in my care or dealing with the photographs from any and all liability which may or could arise from the taking or use of such photographs.

\_\_\_\_\_\_\_ I authorize the use of my photographs for the clinical chart.

\_\_\_\_\_\_\_ I authorize the use of my photographs in Dr. Echo’s Office Photo Album.

\_\_\_\_\_\_\_ I authorize the use of my photographs and/or video in Dr. Echo’s website photo gallery.

\_\_\_\_\_\_\_ I authorize the use of my photographs and/or video on Dr. Echo’s social media.

This authorization does not expire and continues unless revoked. I may revoke or withdraw this authorization at any time unless the use or disclosure process has already occurred. I may withdraw the authorization by contacting Dr. Anthony Echo’s office at 291-737-4560.

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PATIENT PRINTED NAME DOB

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PATIENT SIGNATURE DATE

Note: A copy of this completed, signed, and dated form will be provided to the patient upon request.