



Consent to Taking and Publication of Photographs

Patient's Name: _____

Date: _____

In connection with the medical services that I am receiving from VEGA Aesthetic & Reconstructive Surgery (Stephen J Vega, MD, Chrysa Charno, PA, Karen LeBlanc, RN) (VARs), I consent that photographs may be taken of me or parts of my body, under the following conditions:

1. The photographs shall be taken by either Dr. Vega, Chrysa Charno, PA, or Karen LeBlanc, RN.
2. The photographs may be taken only with the consent of VARs and under such conditions and at such time as may be approved by VARs. Examples include: preoperative, intra-operative, and postoperative clinic follow-up visits.
3. The photographs shall be used for medical records and, at the discretion of VARs, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, for professional medical purposes (in professional journals or medical books), or used for any purpose including internet use that VARs may deem proper, such as medical education and publications in all types of media, patient education, and testing and credentialing purposes provided, however, that it is specifically understood that in any such use I will not be identified by name.
4. **Please be reassured that before any photographs are used for any publications an additional consent will be obtained.**

Signature (Patient or Legal Guardian, if patient is a minor) _____

Print Name of Patient _____

Witness (Signature) _____

Witness (Print Name) _____