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PHOTOGRAPHY CONSENT

I consent to the taking of photographs or video by Dr. Bradley K. Becker, associates or representatives of myself or parts of my body in connection with the procedure/surgery intended to be performed. I understand that photographs may be taken before, during and/or after my procedure or surgery as a routine part of my medical care and that all photographs or video will be kept strictly confidential.

Signature: _____ **Date:** _____

RELEASE OF PHOTOGRAPHS CONSENT

I authorize the use of my photographs or video in the formats listed below. I waive any right to inspect or approve the finish product, advertising or other copy that may be u5ed in connection with the option below. understand that I will never be identified by name in any use of these photographs or video, but that in some circumstances they may portray features which me make my identity recognizable.
Please initial or check **YES** or **No** for each item below:

___YES ___ NO For our office photo album for prospective patients.
___YES ___ NO For our website for prospective patients.
___YES ___ NO For print advertisements or television
___YES ___ NO For our Social media (i.e., Facebook, Instagram, etc.) for prospective patients or for education purposes

I release and discharge Dr. Bradley K. Becker, associates and representatives from all rights and may have in the photographs or video and from any claim I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of photographs or video. This consent may be revoked at any with written consent.
I certify that I have read the above Authorization and Release and fully understand its terms.

Signature: _____ Date: _____
Print Name: _____