PHOTO CONSENT

Please read and initial each point you wish to give your consent.

_____I consent to have my photograph(s) taken to assist in my evaluation and medical treatment. Your photo is only of the area of concern and is for Dr. Burgess' evaluation only.

_____I consent to the use of photographs taken of me, for the discussion with other trained Plastic Surgeons or of those practicing as Plastic Surgeons.

_____I consent for the use of any record, illustration, photograph, or other imaging record created in my case, for use in examination, credentialing, and certifying purposes by The American Board of Plastic Surgery and Dr. Elisa Burgess. (Dr. Burgess feels strongly that board certification is important. Her practice is periodically evaluated and she may share your file, which includes your photographs, with the American Board of Plastic Surgery to continue her high standards of care.)

______________________________________	____________________
Patient/Guardian Signature	**Date**

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