Photo Release Consent Form

We kindly request your consent to use your pre- and post-operative photographs for educational purposes and to help prospective patients visualize potential results. Your photographs will serve as a valuable resource for other patients undergoing plastic surgery procedures, including those with cancer or other medical conditions, by providing realistic expectations and a comprehensive understanding of the process. We want to assure you that we hold your privacy in the highest regard. Your photos will be handled with utmost respect, and measures will be taken to ensure they are protected and used responsibly. Your identity will remain anonymous and no personal identifiers will be used in any presentations or publications. Your cooperation is greatly appreciated and will directly contribute to the enhancement of patient education and care.

I hereby give consent and permission to Dr. Matthew Goodwin or his/her designee to take photos or videos ("images"). These may be of me or parts of my body. They will relate to the procedure(s) done by Dr. Matthew Goodwin. I also agree to the disclosure of such images and information related to the procedure ("information").

I agree that my surgeon can keep my images and I acknowledge that Dr. Matthew Goodwin is the sole owner of all rights. He may share them with other healthcare professionals and members of the public for the following purposes.

Select ONE of the following:

- **ALL MEDIA**- My information may be used in any media. This includes newspapers, pamphlets, educational films and social media.

- **WEBSITE ONLY**- My information may be used on my surgeon's website.

- **NONE**- I do not authorize my surgeon to share my images with other healthcare professionals or members of the public.

I understand that when this information is published, it is no longer protected by privacy laws. It may be re-published by anyone with access.

I understand I will receive no compensation for the appearance or for participation in said productions. I agree to hold Dr. Matthew Goodwin and other parties harmless against claim, liability, loss, or damage caused by, or arising from, my participation in this production.

I understand that I can see and copy the images. I can get a copy of this form. I can revoke my authorization at any time. If I do so, it will not affect the services I receive. If I do not revoke this authorization, it will expire 10 years from the date below.

I have read this consent before signing and fully understand the contents, meaning and impact of this consent. I understand that I am free to address any specific questions and have done so prior to signing this consent.

Name: _____

Address: _____

Telephone: _____ **Email address:**

Signature: _____ **Date:** _____

Name of Parent/Legal Custodian (under age 18): _____

Signature of Parent/Legal Custodian (under age 18): _____

Witness Name:_____

Witness Signature:_____ **Date:** _____