BASSIN CENTER
FOR PLASTIC SURGERY

Dr. Roger Bassin

Photographic Authorization

In connection with the medical services which I am receiving from my physician, Dr. Roger Bassin, I consent to photographs being taken of me or parts of my body under such conditions and at such times as may be approved by him. Moreover:

1. The photographs shall be taken by my physician or by a photographer approved by my physician and shall be used for medical records purposes.

2. The photographs, digital images, or videos shall be used to instruct or edify other patients, potential patients or doctors exclusively for medical reasons.

3. If in the judgment of my physician, medical research, education or science benefited by their use such photographs and information relating to my case may be published and republished, either separately or in conjunction with each other, in professional or public journals or papers or medical books, media or used for related purposes which he may deem appropriate without compensation to me. However, it is specifically understood that in any such publication or use, I shall not be identified by name.

_____	_____
Patient Name	Patient Signature or Legal Guardian
_____	_____
Date	Witness