

CONSENT TO OBTAIN AND PUBLISH PHOTOGRAPHS

PATIENT: _____

DOB: _____

I consent photographs may be taken of me or part of my body under the following conditions:

1. Photographs may be taken before, during and after my surgery or treatment to document my progress as part of my medical record.
2. The photographs may be taken only with the consent of my physician, Sunny Park MD, and under such condition and at such times as may be approved by her.
3. The photographs may be taken by Sunny Park MD or by a photographer approved by her.
4. The photographs shall be used for medical record. In addition, these photographs may be used for the purpose of diagnosis, education, research or for publication, either separately or in connection with each other in Dr. Sunny Park's professional website, Social media sites, professional journals or medical books. In any such publication, I shall not be identified by name. I hereby release Sunny Park MD Inc and its officers, employees and agents from any and all claims arising in any way out of the use described above of such photographs. I further waive the right to inspect and approve such photographs prior to their use.

SIGNATURE _____

PRINT NAME, DATE

SIGNATURE _____

SUNNY PARK, MD