MEDIA RELEASE AUTHORIZATION

Patient Name: (Print) _____ DOB: _____/_____/_____

I consent that the Doctor(s) and staff at Fayetteville Plastic Surgery/Cape Fear Aesthetics MedSpa have the right and permission to publish, use, or assign any, and all photos or videotapes of me taken at this facility for the purpose of: (**CHECK THE FOLLOWING [YES] [NO] AND INITIAL BESIDES IT**)

Procedure Name(s): _____

YES	NO	PURPOSE
		CONTINUING MEDICAL EDUCATION
		PATIENT CONSULTATION/ PRESENTATION
		PUBLICATION (VIDEO OR PRINT)
		WEBSITE
		SOCIAL MEDIA

I further acknowledge that I am not to receive financial benefits from the creation and use of these materials.

If I decide to revoke my consent, I will inform Fayetteville Plastic Surgery/Cape Fear Aesthetics MedSpa in writing.

By signing this form, I am stating that I have read the above statements, prior to its evacuation, and that I understand this agreement.

Patient Signature: _____ **Date:** _____

Address: _____

Phone: _____

Guardian: _____ **Date:** _____

(**If patient is under legal age**)

Witness Signature: _____ **Date:** _____