Chicago Plastic Surgery Center, LLC
Stacie D. McClane M.D.
Facial Plastic and Reconstructive Surgery
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PHOTOGRAPH CONSENT

Patient's Name____

___ Your doctor is hereby authorized to take and exhibit photographs of the above patient before, during, and after treatment These photographs are in the interest of medical science, and is on the condition that they be used for consultations with potential patients in the office to demonstrate a procedure(s).In addition, for scientific purposes only, they may be included in a publication and exhibit to a scientific or medical audience. I waive any and all claims, which I might have at any time against Dr. McClane, in any matter pertaining to these photographs.

____ These photographs are for internal use only. If we should want to use these photographs, For any reason, we will contact you.

Date______________________ Signature__________________________

Witness_____________________