PATIENT NAME_____

CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize the Plastic Surgery Institute of Ohio LLC and Jared C. Storck, DO, FACOS and associates or licensees to use preoperative, intraoperative, and postoperative photographs, slides and/or videotapes for professional medical purposes deemed appropriate including but not limited to showing these images on public or commercial television, newspaper articles/advertising, magazine articles/advertising, electronic digital networks, for purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups.

I also do____ do not_____ authorize the use of my photographs as patient examples in the office or on internet websites which represent Plastic Surgery Institute of Ohio LLC and Jared C. Storck, DO and associates or licensees practice.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and/or my interview.

DATE: _____

PATIENT SIGNATURE:_____

WITNESS:_____