***MarthaJefferson* Aesthetic and Reconstructive Surgery**
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Victoria L. Vastine, MD ***Elizabeth W. Chance, MD*** ***Nicole B. Lepsch, FNP***

Consent to Photograph

Date: ____________________ DOB: ___________________

Name: ____

Please sign ONE of the following statements:

I hereby authorize the staff at Martha Jefferson Aesthetic and Reconstructive Surgery to take photographs to document and compare the before and after surgery results. These photos will be stored in my medical record and also may be used to show other patients the surgeon's work. All photos will be of the affected body part only. Your name or any other identifying information will not be included with any photos used to show other patients.

Signature: ____

I **DO NOT** authorize the staff at Martha Jefferson Aesthetic and Reconstructive Surgery to use my pictures to show other patients who are having the same surgery. I understand that before and after pictures will be taken for my confidential medical record only.

Signature: _______________________________________