PHOTO CONSENT

Permitting use of Photographs/Slides

I hereby give Dr. Benjamin Stong permission to use my photographs in the following manner: **[please initial each line to which you grant permission]**

_____ Use only photos in which my identity is concealed

_____ Unrestricted use of photographs (this may include website)

_____ Use in Dr. Stong's's office to show other patients "before/after" photos

_____ Use in Dr. Stong's's new patient seminars to teach other patients about procedures

_____ Use for medical education/lectures to other physicians

_____ Use in professional writing which may include textbooks, journals, newsletters

The specific restrictions on the use of my photographs include:

_____

_____

_____

I understand that this consent may be revoked in writing (but not by implication) by contacting the following individual in writing:

Benjamin C. Stong, M.D., F.A.C.S.
5670 Peachtree Dunwoody Raod Northeast #910, Atlanta GA 30342
(404) 963-6665

_____ _____

Print Name Date

_____

Signature