Photography Consent

I, ___________________________________, consent to the taking of photographs by Kalos Plastic Surgery (Dr. Benjamin Stong MD) or designee of me or parts of my body in connection with the plastic surgery procedure(s) intended or performed. I understand that photographs may be taken before, during, and after my procedure(s) as a routine part of my medical care.

Signature:___________________________________ Date:__________________________

Release of Consent

I authorize the use of my photographs in the formats listed below. I waive any right to inspect or approve the finished product, advertising, or other copy that may be used in connection with the options below. I understand that I will NEVER be identified by name in any use of these photographs, and that my identity will remain confidential if I so wish.

For our office photo gallery to help future patients understand and see outcomes from surgery with Kalos Plastic Surgery.

To be used on our website or affiliated accounts for prospective patients to see and understand outcomes from surgery with Kalos Plastic Surgery.

I certify that I have read the above Authorization and Release and fully understand its terms.

Print Name: ____ Date: ______________________
Signature: ____
Witness: ____

This consent may be revoked at any time with a written consent.