MICHAEL A. PERSKY M.D., F.A.C.S.

PHOTOGRAPHY CONSENT

I permit Dr. Michael A. Persky to photograph me under the following conditions:

1. The photographs may be taken only with the consent of Dr. Persky.

2. The photographs will be taken by Dr. Persky or a photographer chosen by him.

The photographs may be used for:

- Communication and further education between office staff
- Your medical record
- Furthering medical research, education or science
- Publication in professional journals or textbooks
- Website
- Marketing

I understand that any publication of my pictures shall not identify me by name.

Patient's name____

Patient's signature____

Date______________________

If patient is a minor or is unable to consent:

Parent/Guardian's name____

Parent/Guardian's signature____

Date______________________