DELOZIER
COSMETIC SURGERY CENTER

AUTHORIZATION TO USE PHOTOGRAPHS

This is an authorization to permit Joseph B. DeLozier III, M.D. to use my photographs for patient education purposes-

I authorize the use of these images for the following specific purposes:

Yes	No	Please initial the boxes marked Yes or No for each item
		In the office photo album For prospective patients
		On our website (www.drdelozier.com) for Prospective patients
		Social Media Posting for Prospective patients

I understand that:

1) I will not be identified by name in any of the media described above; however, I also understand that in some circumstances that photographs may display features that identify me (such as necklaces, tattoos, skin markings etc.)

2) I have the right to revoke this authorization in writing at any time and if I decide to do so I must present my written revocation to this office at 209 23rd Ave North Nashville, TN 37203

This authorization is made as a voluntary contribution in the interest of public education. My signature certifies that I have read this authorization and consent carefully and fully understand its terms.

_____

Signature of patient

_____

Print Name of Patient