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 only.

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

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.

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Signature of patient

_____

Print Name of Patient