COSMETIC SURGERY & DERMATOLOGY OF ISSAQUAH, INC.
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PHOTOGRAPHIC CONSENT FORM

Patient Name____________________________________

I authorize my physician, Dr. Michalak, or any of his designated assistants to take photographs of me at any point in my medical management as is considered necessary for my medical records. If my physician feels the photographs are beneficial to medical research or education, such photographs and related information may be published and re-published in professional journals or medical books, or used for other purposes in the interest of medical education for allied medical personnel and lay persons. Identifying features may be visible but I shall not be identified by name in any publications.

These photographs may be modified or retouched in any way that my physician considers desirable.

____________________________________ _______________
Patient Signature **Date**

____________________________________ _______________
Witness Signature **Date**