EYE & FACIAL
PLASTIC SPECIALISTS
Dr. Donald Hollsten & Dr. Jordan Hollsten

PHOTOGRAPH CONSENT AND RELEASE

PATIENT NAME _____ **DATE** _____

MEDICAL RECORDS (please initial)

_____ I hereby acknowledge and understand that photographs will be taken of my face and parts of my face before and after surgery. I understand that these photographs will only be used for documentation in my medical record unless otherwise permitted. *See "Other Permissions."*

OTHER PERMISSIONS (please initial by the options to which you consent)

_____ **PHOTOGRAPHS**
I hereby give my consent for Donald A. Hollsten, M.D. and Jordan Hollsten, M.D. to use selected photographs on their website and professional social media platforms with basic details of my medical/surgical procedure to inform the public about specific plastic surgery methods and results. I understand that these photographs will be cropped and limited to specific parts of my face in order to protect patient confidentiality.

_____ Please initial here if you will allow our office to use the full image of your face without cropping.

_____ **VIDEOS**
I hereby give my consent for Donald A. Hollsten, M.D. and Jordan Hollsten, M.D. to use video documenting my medical procedure on their website and professional social media platforms with basic details of the procedure to inform the public about specific plastic surgery methods and results.

_____ **TESTIMONIALS**
I hereby give my consent for Donald A. Hollsten, M.D. and Jordan Hollsten, M.D. to use my personal written testimonial on their website and professional social media platforms. I understand that my testimonial will be quoted, followed by my first name and last initial and may include a brief descriptor of my medical/surgical procedure in order to provide better context.

By signing this form, I acknowledge my consent as initialed above, and I further recognize that this consent form will supersede any other photo consent forms with a date prior to the date written below. This consent may be revoked at any time by written request or by completion of a new form.

SIGNATURE _____ **DATE** _____

Ophthalmic Plastic and Reconstructive Surgery
4114 Pond Hill Road • Suite 100 • San Antonio, Texas 78231
T: (210) 616-0739 • F: (210) 616-0972
eyefacialplasticspecialists.com