366 Broadway Suite 100
Somerville, MA 02145

T (617) 628-8000
F (617) 628-2370

PHOTOGRAPHIC AUTHORIZATION AND RELEASE

Dr. Timothy Osborn, M.D.,D.D.S., FACS & Dr. Eva Wardius, DMD, CAGS

I consent to the release of the photographs taken of me, or parts of my body, to C.M.F Cranio-Maxillofacial Surgery Associates, with respect to my surgery treatment.

I understand that such photographs shall become the property of C.M.F Cranio-Maxillofacial Surgery Associates and may be retained by, or released by C.M.F Cranio-Maxillofacial Surgery Associates for PUBLICATION OR REPUBLICATION in any PRINT, VISUAL, ELECTRONIC (INTERNET WEB SITE) OR BROADCAST MEDIA for any
purpose which the C.M.F Cranio-Maxillofacial Surgery Associates deems appropriate to inform the medical profession or the general public about surgery methods. The media may include, but are not limited to, the following: MEDICAL JOURNALS AND TEXTBOOKS, PAMPHLETS, NEWSPAPERS, MAGAZINES, and VIDEO TAPES.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that shall make my identity recognizable.

I release and discharge the Plastic Surgery Center, PA and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I have relating to such use and publication, including any claim for payment in connection with distribution or publication of the photographs.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above authorization and release and fully understand its terms.

PATIENT______________________________

SIGNATURE___________________________ DATE________________

WITNESS______________________________

I have read the Authorization and Release. I am the parent, guardian or conservator of____________________________, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

To cancel this agreement, a letter must be sent to C.M.F Cranio-Maxillofacial Surgery Associates advising of my wish to cancel my authorization to release photograph(s) or digital image(s) taken by the practice. Sign and date by authorized representative.