

Bayside Center for Plastic, Reconstructive and General Surgery

Dr. John B. Roach, Jr.

Consent for Photography

I, \_\_\_\_\_

Consent to the photographing and/or televising of the operation(s) or procedure(s) to be performed including appropriate portions of my body for Medical, Marketing, Scientific or Educational Purposes, provided my identity is not revealed by the pictures.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_