Travis T. Tollefson, M.D., F.A.C.S. Facial Plastic and Reconstructive Surgery Department of Otolaryngology/Head and Neck Surgery

RECORD OF AUTHORIZATION FOR TAKING AND PUBLICATION OF PHOTOGRAPHS

In connection with the medical services I am receiving from my physician, Travis T. Tollefson, M.D., F.A.C.S. I consent that clinical photographs may be taken of me, my face or parts of my body with the understanding that such photographs will remain the property of Dr. Tollefson. If in Dr. Tollefson's judgment, these photographs can be used to promote patient understanding or education, medical student education, medical research, or surgical knowledge, by the use and publication of these photographs or related information, then this document is my consent that these photographs and related materials may be displayed, published and republished in professional journals or medical books, on websites or in videos, or used for purposes Dr. Tollefson may deem proper. It is specifically understood that in any such publications or use, I shall not be identified by name. I understand that this consent shall remain in effect indefinitely unless I request Dr. Tollefson in writing to have it revoked.

I certify this form has been fully explained to me, that I have read it or have had it read to me and that I understand its contents.

Patient/Other Legally Responsible Person Signature	// Date	Time
Witness	// Date	Time
Name	MR #	