PHOTOGRAPH RELEASE AND CONSENT

I, _____ agree that Aesthera Plastic Surgery may use my preoperative/ pre-procedure and postoperative/post-procedure photographs of my person for confidential clinical record purposes.

Patient Signature _____ Date _____

I authorize Dr. Vishwanath“CV” Chegireddy to use my photographs and videotapes in the following setting indicated by my initials below:

____ Aesthera Plastic Surgery office patient educational materials, printed materials, including lectures

____ Aesthera Plastic Surgery personal website or web page

____ Aesthera Plastic Surgery Social Media (e.g. Facebook, Instagram, etc.)

____Aesthera Plastic Surgery press or media including published materials, press releases, interviews, and articles, in relation to plastic surgery.

Patient Signature: _____ Date: _____

Printed Name: _____ Witness: _____