

## Picture Release

I, \_\_\_\_\_, am a patient of Statesboro Plastic Surgery. I give my permission to Statesboro Plastic Surgery to utilize my preoperative and postoperative photographs to be shown to future patients, in medical journals, at public presentations, and on the website at [www.statesboroplasticsurgery.com](http://www.statesboroplasticsurgery.com) for the purpose of education and information.

I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by the The American Board of Plastic Surgery, Inc.

I understand that the pictures will be cropped to assure discretion and that any distinguishing marks will be eliminated.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness