Clear Form

Anthony P. Sclafani, M.D., F.A.C.S.

Facial Plastic & Reconstructive Surgery

CONSENT FOR PHOTOGRAPHY

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Diplomate, American Board of Facial Plastic & Reconstructive Surgery

Diplomate, American Board of Otolaryngology

Fellow, American Academy of Facial Plastic & Reconstructive Surgery

Fellow, American College of Surgeons

Fellow, American Academy of Otolaryngology- Head & Neck Surgery

Professor of Otolaryngology
New York Medical College

Past President,
New York Facial Plastic Surgery Society

I, the undersigned, _____ , am a patient of Anthony P. Sclafani, MD and consent to be photographed as relates to my treatment. This may be performed before, during or after treatment, in either the physician's office or operating room.

In the course of consultation and discussions with Dr. Sclafani and his staff, I may have been shown or provided certain brochures, pictures of actual patients or pictures of myself on an electronic imaging device. I do understand that those pictures and alterations of these pictures seen are solely for the purpose of illustration, discussion and to provide improved communications with medical professionals. I do understand that the outcome of any type of surgical procedure is directly related to my individual characteristics and health. I further understand and acknowledge that because of the obvious significant differences in how living tissues react to surgery, there may be no relationship between the electronic images created, and my actual final surgical result. Use of the computer imaging system offers an opportunity for me to discuss my desires and to allow improved communication with the medical staff.

I certify my understanding that there is NO WARRANTY, expressed or suggested, as to my own final appearance after elective surgery by the use of these electronically altered images.

The undersigned grants to Dr. Sclafani the on-going and unrestricted use of the undersigned's photographs and altered electronic images for general information, education, scientific and medical purposes at any time during or after treatment, with complete confidentiality of the my identity.

The undersigned further acknowledges that he/she relinquishes all right, title, and interest in these photographs, or any right to profit or gain directly or indirectly realized through the use of these photographs. The persons to whom disclosure may be made include physicians, medical students, patients, and prospective patients, examining boards, medical and other periodicals, medical editors, insurers (if any), outside firms, the staff of the American Academy of Facial Plastic & Reconstructive Surgery (AAFPRS) and the AAFPRS Foundation or other academic/scientific organization, readers of medical literature and the general public.

This consent may only be revoked in writing, signed by the undersigned and delivered to Dr. Sclafani at his office. Such revocation shall thereafter be effective as to any further use not already committed to by Dr. Sclafani. Unless earlier revoked, this authorization will expire on the end of the treating physician's practice of facial and reconstructive surgery, except there will be no expiration for the purpose of medical or scientific research. Revocation will not affect uses and disclosures made before receipt of the revocation. If the photographs are disclosed, there is obvious potential for redisclosure some of which would not be subject to this authorization. This consent is in consideration of services performed and consultations conducted or to be performed or conducted by Dr. Sclafani, and there have been no representations or inducements concerning this consent except as set forth herein. The treating physician will not condition treatment on whether the individual signs this authorization, but if any portion of the treating physician's services is to be covered under any insurance or third-party-payment plan, the signing individual will be responsible for authorizing release as required by that insurance or third-party-payment plan.

_____ _____

Signature ***Date***

_____ _____

Witness ***Date***

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