COMPUTERIZED IMAGING RELEASE FORM

Patient Name:_____ Date: _____

I grant permission to Dr. Prescott, or an assistant designated by him, to obtain a computerized image of my face and/or body. I understand that these images are obtained primarily for pre and postoperative comparisons. The image may also be manipulated to suggest a possible outcome after surgery, however these images may or may not be accurate in approximating true surgical outcome. This is due to the unpredictable nature of tissues and constraints of individual anatomy.

I understand that these images are not stored or saved as a part of my medical record.

I have read and understand all of the above.

Patient/guardian signature: _____

Date: _____

Witness: _____