3270 Joe Battle, Suite #360
El Paso, TX 79938

Phone: 915.351.9000
Fax: 915.351.9041

PHOTOGRAPHY CONSENT

"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 American Board of Plastic Surgery, Inc."**
*Please note camera source may be an iOS device. **Signing this consent form does NOT allow our office to use your picture on our website or any other advertising material, it is SOLEY for the use of your in house medical record.**

____________________________________ **PATIENT NAME**

____________________________________ **PATIENT/GUARDIAN SIGNATURE**

____________________________________ **WITNESS SIGNATURE**

____________________________________ **DATE**

The Board requires that all identifiable characteristics, with the exception of a full face photograph or photograph of a uniquely identifiable characteristic, be blanked out for submission of materials for the Oral Examination of The American Board of Plastic Surgery to protect patient privacy.

****PLEASE NOTE: THIS FORM MUST BE SIGNED IN ORDER TO HAVE ANY PROCEDURE PERFORMED**

Adopted: 10/15
Revised: 5/16