M. SCOTT HAYDON, M.D.
CONSENT FOR RELEASE
OF PHOTOGRAPHS

Photographs will be taken before and after surgery for documentation. We would like to ask your permission to use these photographs to show to future patients, and *possibly* on our website gallery. This gives patients a realistic idea of the results they can expect should they choose to have a similar procedure. Rest assured that your identity will be kept confidential.

Initial the following:

_____Yes, you may use my photos to show future patients

_____No, please do not use my photos

I acknowledge that photographs may be taken of my body in connection with the medical services to be performed by my physician.

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Patient Signature Date

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Parent/Guardian Signature Date