Arkansas Oculoplastic Surgery, PLLC

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CONSENT TO PHOTOGRAPHY

Please initial all that apply:

________ Initial — I hereby authorize photographs to be taken for medical purposes. I agree to the use of the prints, copies or reproductions for insurance documentation, teaching and for monitoring my condition.

________ Initial — I hereby authorize Arkansas Oculoplastic Surgery, PLLC to use any photographs concerning my condition and/or treatment to be posted in the "before and after" gallery of their website for the purposes of demonstration and/or education.

________ Initial — I hereby authorize Wade Brock, MD or Michael Chappell, MD of Arkansas Oculoplastic Surgery, PLLC to add pictures or video of me to his Snapchat story. This is available to followers for 24 hours. The pictures and video may include operative, nonoperative, before and after or other photos/videos. This action is by my request.

________ Initial — I hereby authorize Wade Brock, MD or Michael Chappell, MD of Arkansas Oculoplastic Surgery, PLLC to post photos or videos of me on other social media such as Facebook or Instagram. This action is by my request.

PATIENT NAME: ____ DOB: _____________

PATIENT SIGNATURE: ____ DATE: ______________

WITNESS SIGNATURE: ____ DATE: ______________

If the patient is a minor or unable to sign, complete the following:

____
Father

____
Mother

____
Guardian or other person/relationship