

**California Institute of Cosmetic & Reconstructive Surgery**  
**Vipul R. Dev, M.D./Narayanan M. Nair, M.D.**  
**Consent for Medical Photography, Television, or Videotape Recording**

Dear Patients,

Dr. Dev/Dr. Nair often take pre-operative, intra-operative, and post-operative photographs of patients to help them provide the best care possible for you. These photographs are very useful for planning your surgery and evaluating the outcome of your procedure. We respect your privacy and will often only take these photographs or videotape with your express consent. In addition to using these photographs or videotapes for your own medical care, Dr. Dev/Dr. Nair often give lectures to patient groups and to physicians at national meetings. In these settings, the photographs or videotape would be used for educational purposes. We wish to obtain your express consent for these applications as well. Sometimes these photographs or videotape are used in print, online, and/or television media as well. We will only do this if you choose to give your consent for this purpose. We have very clear guidelines for how we take these photographs.

**(Please initial all paragraphs that you agree to participate in)**

**Consent for Photographs or Videotape**

\_\_\_\_\_ I, the undersigned, do hereby consent and agree that Dr. Dev/Dr. Nair, their employees, or assistants have permission to take photographs or videotape of me beginning on the first day that I am seen in consultation. This also includes permission to take additional photographs or videotape of my body in the operating room while I am under anesthesia as well as additional photographs or videotape in the office during post-operative follow-up visits.

**Consent for use of Photographs or Videotape for Education and Research**

\_\_\_\_\_ I, the undersigned, do hereby consent and agree that Dr. Dev/Dr. Nair may use these photographs or videotape in any and all media, now or hereafter known, and exclusively for the purpose of patient education, physician education, and research. I further consent that my photographs may be used without my name being mentioned in a descriptive text or commentary. I do hereby release to Dr. Dev/Dr. Nair, their agents, and employees all rights to exhibit this work in print and electronic form publicly or privately. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used. I understand that there will be no financial or other remuneration for recording me, either for initial or subsequent transmission or playback. I also understand that Dr. Dev/Dr. Nair are not responsible for any expense or liability incurred as a result of my participation in this recording, including medical expenses due to any sickness or injury incurred as a result.

**Consent for Use of Photographs in Print, Internet, or TV Media**

\_\_\_\_\_ I, the undersigned, do hereby consent and agree that Dr. Dev/Dr. Nair may use these photographs or videotape in any and all media, now or hereafter known, in printed media such as magazine or newspapers, in video media such as television, or in internet media. I further consent that my photographs may be used without my name being mentioned in a descriptive text or commentary. I do hereby release Dr. Dev/Dr. Nair, their agents, and employees all rights to exhibit this work in print and electronic form publicly or privately. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used. I understand that there will be no financial or other remuneration for recording me, either for initial or subsequent transmission or playback. I also understand that Dr. Dev/Dr. Nair are not responsible for any expense or liability incurred as a result of my participation in this recording, including medical expenses due to any sickness or injury incurred as a result.

I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement.

**Patient Agreement Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Refusal Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_