PHOTOGRAPHY RELEASE

This document arranges for a complete release of all photographs taken before, during, and after surgery. By signing this document, I consent to the use of my photographs as examples for other patients, in medical journals, in scientific presentations, in patient information brochures, my medical record, insurance purposes, and in advertising for Dr. Peters.

All body and breast images do not have any portion of the person's facial features shown.

I, ______________________________ agree to all of the above.

________________________________ ____________________
Signature Date

________________________________ ____________________
Witness Date

1010 Lake Street, Suite 619, Oak Park IL, 60301 - Ph: 708.524.1400 - Fax: 708.524.1441
www.plasticsurgeryofchicago.com