St. Croix Plastic Surgery & MediSpa
Dr. Robert F. Centeno
12 Beeston Hill
Christiansted, VI 00820
340-719-2777

PHOTO CONSENT FORM

I understand that photographs will be taken before, during, and after my procedure(s) as a routine part of my medical care. I further understand that these photographs will be kept strictly confidential. I, ____ authorize Dr. Robert F. Centeno, or a representative to take photographs, slides, or videos of me for the following procedure(s) for medical purposes to be used for my care, insurance predeterminations, medical presentations and/or articles, examination, testing, credentialing and /or certification purposes by the American Board of Plastic Sugery Inc..

Signature:________________________________Date:_______________________________

Strict Confidentiality Will Be Maintained.

Additionally, I authorize the use of these images: (Please initial Yes or No for each of them)

______ YES ______ NO	For demonstration purposes including an **office photo album or seminar** for prospective patients.
______ YES ______NO	On our **website** for prospective patients.
______ YES ______ NO	In print **advertisements.**
______ YES ______ NO	On **television.**

Print Name: _______________________________ Date: ______________________

Signature: _________________________________

Witness: __________________________________

A photocopy is valid as the original.

This consent can be revoked at any time with a written request.