

**JACKSONVILLE WEIGHT LOSS CENTER
JACKSONVILLE SURGICAL ASSOCIATES, P.A.**

CONSENT FOR TAKING AND PUBLISHING PHOTOGRAPHS

Patient: _____

Date: _____

In connection with the medical services that I am receiving from my physician, Dr. Cywes, I consent that photographs may be taken of me or parts of my body, under the followed checked conditions:

1. The photographs may be taken only with the consent of my physician and under such conditions and at such times as may be approved by him.
2. The photographs shall be taken by my physician or by a photographer approved by my physician or me.
3. The photographs shall be used for medical records, and if in the judgment of my physician, medical research, education or science will be benefited by their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose that may be deemed proper in the interest of medical education, knowledge, or research; provided however, that it is specifically understood that in any such publication or use I shall not be identified by name.
4. The photographs may be used for marketing purposes by and for Jacksonville Surgical Associates, P.A., provided however, that it is specifically understood that in any publication or use I shall not be identified by name unless I specifically consent in writing for that sole purpose.

Signature: _____

Print Name: _____

Date: _____

I hereby consent to use of my name as per paragraph #4

Signature: _____