NORTH TEXAS
FACIAL PLASTIC SURGERY

Photo Release

I, the undersigned, do herby give permission to **Colin D. Pero, M.D.,** or his assistant, to take photographs for identification purposes, diagnostic purposes, and enhancement of the medical report. I agree that these photographs will remain their property. I further authorize them to use such photographs for teaching purposes or to illustrate scientific papers, books, or lectures if, in their judgment, medical research education, public education or science will be advanced by their use. It is specifically understood that in any such publication or use, I shall not be identified by *name.*

Pre-Procedure

☐ By checking this box, I consent to have my photograph taken for pre-procedure use.

Post-Procedure

☐ By checking box, I consent to have my photographs used on a website and used and maintained by Dr. Colin Pero (including but not limited to northdallasent.com or drpero.com) for the use of furthering patient education.

Print Name of Patient:_____

Signature of Patient or Legal Guardian:_____

Relationship to Patient (If applicable):_____

Witness:_____ Date:_____

5425 W Spring Creek Parkway #170
Plano, TX 75024
Phone: 469-429-9247 Fax: 469-429-9247