
**Photograph Consent and Release Form**

I, hereby give permission to Dr Antony Arvind or his designated representatives to obtain photographs and/or video recording of my body part in connection with the plastic surgery procedure(s) intended or performed.

I understand that photographs may be taken before, during, and after my procedure(s) as a routine part of my medical care.

I further understand that these photographs shall remain the property of Dr Antony Arvind. Specifically, the photographs, videos, recordings, or case information may be used for the office photo album or gallery as educational material for prospective patients, medical textbooks or journals.

I certify that I have read the above consent and release form and fully understand its terms.

Patient Name(print):_____ Date:_____

Patient Signature : _____

Phone Number: _____