



CONSENT FOR RELEASE OF MEDICAL RECORDS TO THE AMERICAN BOARD OF PLASTIC SURGERY

I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

CONSENT TO TAKE PHOTOGRAPHS OR VIDEOTAPES

I hereby authorize Dr. Sarah A. Mess or her assistant *to take* pre-operative, intra-operative, and post-operative photographs.

Patient Signature _____ Date: <Date>

Guardian (if minor) _____ Date: <Date>

Witness Signature _____ Date: <Date>

CONSENT TO USE EMAIL FOR COMMUNICATION BETWEEN PATIENT AND DR. SARAH MESS'S OFFICE.

I hereby authorize Dr. Sarah A. Mess or her assistant to communicate and send photos through email.

Patient Signature _____ Date: <Date>

Guardian (if minor) _____ Date: <Date>

Witness Signature _____ Date: <Date>