

DAVID L. RASMUSSEN, M.D., P.A.

Arlington Cosmetic Surgery Center

1017 W. Randol Mill Road • Arlington, Texas 76012 • (817) 469-1163

PERMISSION FOR PHOTOGRAPHY

I hereby give permission to take necessary clinical photographs of (name) _____ with the understanding that such photographs are for confidential, clinical record purposes, and that all photographs remain the property of the doctor.

Occasionally such photographs are used for teaching purposes and for ethical surgical publications for the advancement of surgical knowledge. I will / will not permit the use of these photographs for such ethical professional purposes.

Patient's / Parents' signature _____

Date _____

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