

James Kadi, M.D.
Plastic & Reconstructive Surgery and Medical Spa

Photograph Consent and Release

*I consent to the photographing of myself. I understand that these photographs will become a part of my medical record and are the property of James Kadi, M.D. I understand that these photographs will NOT be shown to other patients, nor will they be used in any publications, unless I consent to that below. I understand that if I **do** consent to any of the following uses of my photographs, that my **name will not be used** in conjunction with it.*

- I **do not** consent to the use of my photos to show other patients or for publications.*
- I **do** consent to the use of before and after photos of my face and/or body to show other patients.*
- I **do** consent to the use of before and after photos of my face and /or body for publications.*

Signed: _____

Date: _____