Gregory A. Buford, M.D., F.A.C.S.

CONSENT TO TAKE AND PUBLISH PHOTOS

In connection with the medical services I am receiving from my Physician, Gregory A. Buford, M.D., F.A.C.S., I consent that photos may be taken of me and used under the following conditions:

1) The photos may be taken only with the consent of my physician and under such conditions as may be approved by my physician.
_____ (initials)

2) Photos shall be taken by my Physician or his representative.
_____ (initials)

3) My photos shall be used as deemed appropriate by my Physician, provided, however, that it is specifically understood that I shall not be identified by name.
_____ (initials)

_____
Signature (Parent or legal guardian if patient is a minor)

_____
Print name of Patient

_____
Witness

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8/2/12