JEFFREY C. DAWES MD, FRCSC
PLASTIC AND DERMATOLOGIC SURGERY

CONSENT TO THE TAKING AND USE OF PHOTOGRAPHS

Name of Patient _____DOB_____

I hereby consent to and authorize Jeffrey C. Dawes Plastic and Dermatologic Surgery and its employees to record by means of still photographs of the above named patient and to reproduce, exhibit or publish these works for the purposes set out herein. Your name will not be attached to any photo. If your procedure does not involve your face, then your face will also not be shown.

Please circle Yes or No below to indicate your consent

Yes/No MEDICAL PURPOSES: For use only by our office and any of your other health care providers for the purpose of diagnosis and documentation of treatment progress.

Yes/No OFFICE PHOTO ALBUM: For use in office only to help future patients understand and see outcomes from surgery.

Yes/No MEDICAL AUDIENCES: Share with other health care professionals, scientific or professional publication, at lectures, or in exhibitions to scientific or medical audiences.

Yes/No WEBSITE/MEDIA/MARKETING: To be used for publication on our website, other social media and/or marketing purposes

Please list any distinguishing features that you would like to be removed/blocked from photos with editing ie. tattoos, birth marks, moles;

_____

I hereby waive any, and all claims, which I may at any time have against Jeffrey C. Dawes Plastic and Dermatologic Surgery or its employees, in any matter whatsoever relating to the said photographs.

I represent that I am 18 years of age or older, or am the legal guardian of the above named patient. I hereby consent to the foregoing on the patients behalf.

Read before signing

_____ _____
Signature of Patient or Authorized Person Date (month/day/year)

_____ _____
Signature of Witness Date (month/day/year)

102 - 47 Sunpark Dr. S.E. Calgary, AB T2X 3V4
Ph: 403-571-3141 Fx: 403-571-3140

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Plastic Surgeon Office Personal Information Consent Form

We are committed to protecting the privacy of our patients and utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use and disclose. In addition to the circumstances described in the form, we also collect, use and disclose personal information when permitted or required by law.

We collect information from our patients such as names, home addresses, home telephone numbers, work telephone numbers and email addresses (collectively referred to as “contact information”).

Contact information is collected and used for the following purposes:

- To open and update patient files
- To invoice patients for treatments/procedures, to process credit card payments
- To process provincial health care claims
- To send reminders to patients concerning the need for follow up treatment
- To send patients informational material about our Plastic Surgery Practice

Plastic Surgeons are regulated by The College of Physicians and Surgeons of Alberta, which may inspect our records and interview our staff as a part of its regulatory activities in public interest.

I consent to the collection, use and disclosure of my personal information as set out above.

_____	_____	_____
Date (mm/dd/yy)	Print Patient Name	Patient Signature
_____	_____	_____
Date (mm/dd/yy)	Print Witness Name	Witness Signature

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