AUTHORIZATION FOR PHOTO RELEASE

I, ______________________________________, give Dr. Mecinski and his associates my permission to use photos of my procedure results for promotional and educational purposes.

I understand that my name will not be revealed in any photo, on any source. If the surgery was performed above the shoulders, (ex. MOHS closure), I may be recognizable.

I understand that my pre-procedure and post-procedure pictures will be included, along with details about the procedure.

I understand that these photos can be found in the photo books used in the office, on our website, at www.mecinski.net, or on our Facebook or Instagram pages.

Upon my signature below, I have fully read and understood all the terms of this photo release.

____ ____________________

Patient Signature Date

84 THOMAS JOHNSON COURT, SUITE C, FREDERICK, MD 21702
(P) 301-378-2015 (F) 301-662-4011