

MR#: _____ Patient Name: _____ DOB: _____



6752 Rock Spring Road, Suite 200
Wilmington, N.C. 28405
(910) 798-5347 Fax: (910) 798-4951

CONSENT FOR USE OF WRITTEN TESTIMONIAL, AUDIO, VIDEO AND PICTURE	
INDIVIDUAL'S NAME (PLEASE PRINT)	
<p>I hereby consent to the use of my written testimonials, pictures, voice and/or video recordings for use in any advertising, marketing, publicity, networking or public relations for DermOne Dermatology, Cosmetic & Scarless Vein Center and Kamran Goudarzi, MD, PA. I further understand that no royalty, fee or other compensation of any character shall become payable to me by DermOne Dermatology, Cosmetic & Scarless Vein Center and Kamran Goudarzi, MD, PA. I understand that my consent to use my words, picture, video and/or voice recording is voluntary and my refusal to grant consent will have no effect on any benefits or treatment to which I may be entitled. I further understand that I may at any time exercise the right to cease being filmed, photographed or recorded and may, in writing, rescind my consent for previous materials to be used in future advertising contracts.</p>	
PLEASE CHECK ONE:	
<input type="checkbox"/>	My full name may be used to identify my testimonials, pictures, voice and video.
<input type="checkbox"/>	Only use my first name to identify my testimonials, pictures, voice and video.
<input type="checkbox"/>	Do not use my name to identify my testimonials, pictures, voice and video.
<input type="checkbox"/>	I DO NOT authorize use of photos or recordings for any purpose.
INDIVIDUAL'S SIGNATURE	
DATE	
WITNESS SIGNATURE	
DATE	

*No pictures or recordings of any type will ever be done without the patient's knowledge and approval.

Would you like to receive our newsletter by e-mail?

<input type="checkbox"/>	Yes, my email address is: _____
<input type="checkbox"/>	No