PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I_____consent to the release of photographs taken of myself, or parts of my body, with respect to my plastic surgery treatment to Val Lambros, M.D. This release includes the following photographs taken by Dr. Lambros or his designated associates:

_____

_____

I waive the right to review the photographs and have no objections to their use for the purposes stated in this release._____Patient Initials

I understand that such photographs shall become the property of Val Lambros, M.D. and may be retained by Dr. Lambros or released by Dr. Lambros for PUBLICATION OR REPUBLICATION in any PRINT, VISUAL ELECTRONIC (INTERNET) OR BROADCAST MEDIA for any purpose which Dr. Lambros deems appropriate to inform the medical profession or the general public about plastic surgery methods. The media may include, but are not limited to the following: MEDICAL JOURNALS AND TEXTBOOKS, PAMPHLETS, NEWSPAPER, MAGAZINES, VIDEO TAPES, TELEVISION OR VISUAL ELECTRONIC (INTERNET).

I agree and authorize Dr. Lambros to place my photos, film or video on his professional web site. Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that shall make my identity recognizable.

I release and discharge Dr. Lambros and all parties acting under his license and authority from all rights that I may have in the photographs and from any claim that I have relating to such use and publication, including any claim for payment in connection with distribution or publication of the photographs.

Dr. Lambros has answered all of my questions to my satisfaction. I grant this consent as voluntary contribution in the interest of public education and certify that I have read the above authorization and release and fully understand its terms.

Patient Signature:_____Date:_____

Witness:_____Date:_____

Val Lambros, M.D., F.A.C.S.
360 San Miguel Dr., Suite 406
Newport Beach, CA 92660
(949) 759-4733
(949) 759-5458 FAX

PATIENT REQUEST FOR RELEASE OF MEDICAL RECORDS

Date: _____

Patient Name: _____

D.O.B. _____

Social Security # _____

I hereby authorize Val Lambros, M.D. to release my medical records to:

_____

_____

_____

Please send copies of the following:

All Records _____ Office Transcription _____ Lab Reports _____ Photos _____

Signature:_____ Date:_____

Val Lambros, M.D.
AESTHETIC PLASTIC & RECONSTRUCTIVE SURGERY
360 San Miguel, Suite 406
Newport Beach, California 92660
Fax (949) 759-5458
Telephone (949) 759-4733

Requirements for physical exam, medical clearance, EKG and laboratory tests:
Physical exam and medical clearance may be completed 6 months prior to surgery.
EKG and Laboratory tests must be completed no more than 1 month prior to surgery.
Please have results faxed to our office as soon as available. (949) 759-5458

Physical Exam

Medical Clearance

EKG

Laboratory (CBC, PT, PTT,CMP, LIPIDS, UA DIPSTICK, HCG QUAL (if applicable)

Other