

HOLZMAN PLASTIC SURGERY

AT THE PLASTIC SURGERY CENTER OF AUSTIN
www.austinplasticsurgery.com

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AUSTIN, TX 78731
512-338-4404

Release to Take and Use Photographs

PATIENT: _____ DOB: _____

TREATMENTS: _____

Photographs will be taken for documentation purposes. Do you authorize Steven Holzman, MD PA to use these photos in the following ways:

Circle your answer and initial.

Yes No For inclusion in your medical record? _____(initial)

Yes No For the purposes of teaching and/or research (your identity will not be revealed)?
_____(initial)

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Signature of Patient (or Person Authorized)

Date _____

Signature of Physician or Assistant

Date _____