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I, _____, hereby allow Dr. Yerukhim and his office to use the following of my personal information:

Please pick ONE of the following:

A. [ ] Pre- and post-operative photographs **or**
B. [ ] Pre- and post- operative photographs, but ONLY with my eyes blocked out for privacy **or**
C. [ ] I DO NOT ALLOW MY PHOTOS TO BE USED IN ANY WAY

If you selected option A or B, please check all information that can be shared:

[ ] My name

[ ] My age

[ ] My feedback comments

I hereby allow the use and sharing of this information in the following manner:
Please check all that apply:
[ ] In professional publications and presentations
[ ] On Dr. Yerukhim's website and social media
[ ] As part of Dr. Yerukhim's general public advertisements
[ ] You may share my contact information with prospective patients considering the same treatment as I have received, as that I can share my experiences with them.

Please Initial:

_____I understand that by signing this release, I allow Dr. Yerukhim and his staff to use my picture and likeness as they deem appropriate, with the above marked limitation and in good faith, to promote their services, advance the science of their practice, and improve patient care.

_____I understand that I have no obligation to grant this permission that my care will in no way be affected by this decision, and that I can withdraw or alter these permissions at any time.

_____ _____
Name (Printed) Date

_____
Name (Signature)

_____ _____
Witness Date