

**AUTHORIZATION FOR AND RELEASE OF  
MEDICAL PHOTOGRAPHS / SLIDES / AND/OR VIDEO FOOTAGE**  
Dr. Matthew H. Conrad 1700 Waterfront Pkwy Bldg 200 Wichita, KS 67206  
**AUTHORIZATION FOR RELEASE OF PATIENT IMAGE**

**CONSENT FOR PHOTOGRAPHY**

I hereby authorize Matthew H. Conrad, MD and his associates to take photographs, slides, and/or videotapes appropriate for my surgery. In addition, I authorize Matthew H. Conrad, MD and his associates to take photographs, slides, and/or videotapes of my consultation concerning my surgery.

I further authorize Matthew H. Conrad, MD to use the photographs, slides and/or videotapes for professional medical purposes deemed appropriate including but not limited to showing the photos, slides, and/or videotapes on public or commercial television, and all other electronic media, or using the photographs, slides and/or videotapes for purposes of medical publication, lay publication, medical education, patient education or during lectures to medical or lay groups.

I understand that I will not be entitled to any payment or other form of remuneration as a result of any use of the photographs, slides, and/or videotapes of my surgery and/or the consultation concerning that surgery.

I hereby grant permission for the use of any of my medical records, illustrations, photographs, or other imaging records created in my case, for use in examination, testing, credentialing, and/or certifying purposes by the American Board of Plastic Surgery, Inc. The Board requires that all-identifiable characteristic, with the exception of a full-face photograph or photograph of uniquely identifiable characteristics, be blanked out for submission of materials for the Oral Examination of the American Board of Plastic Surgery to protect patient privacy.

\_\_\_\_\_ Initial here if you do not wish for Dr. Conrad to use your photos for the above mentioned purposes.

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Patient Signature (and or Guardian)

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Witness

**SMOKING ALERT**

Smoking can interfere with healing after surgery, particularly in the cases of breast reduction, facelift, abdominoplasty, and other procedures that involve the creation of skin "flaps".

Smoking constricts blood vessels and decreases blood flow all over the body. Even more important, the carbon monoxide in cigarette smoke greatly reduces the blood's ability to carry oxygen, which is essential for wound healing. Smoking **(including exposure to second hand smoke)** slows healing and if a skin flap was used, the wound may not heal at all.

If you have general anesthesia and also smoke, you may develop a hard cough that can cause internal bleeding. For all of these reasons, **smoking is contraindicated for all surgical patients.**

If you cannot give up smoking for 6 weeks before and after the operation, your surgeon will want to rethink your decision to have plastic surgery. People choose to have plastic surgery to improve their looks and sense of well being, so it makes little sense to jeopardize the results by failing to forego smoking for several weeks. If you are a smoker trying to quit, this may be an excellent opportunity to give up the habit altogether.

**NO NICOTINE PATCHES OR NICOTINE GUMS CAN BE SUBSTITUTED DURING THIS SAME TIME PERIOD. THIS ALSO INCLUDES EXPOSURE TO SECOND HAND SMOKE.**

I certify that I am not smoking as per my surgeon's request and am not taking any nicotine containing products. I have read the above statement and understand the dangers of smoking and post op complications. I certify that I will tell my physician if I am not compliant with this document.

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NAME

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DATE