# CONSENT AUTHORIZATIONS

## Consent to Treatment and Other Authorizations

I hereby consent to medical treatment rendered by Dr. Edmond and/or Samer W. Cabbabe also acknowledge my receipt of the physician's current Privacy Notice. If my treatment requires billing to my insurance carrier, I hereby authorize release of any medical information necessary to bill my insurer, and authorize payment of medical/surgical benefits to be made to Plastic Surgery Consultants or Dr. Edmond and/or Samer Cabbabe.

DATE: _____ SIGNATURE: _____

## Photography Release

I understand that pre-treatment and post-treatment photographs are necessary to follow my medical care. My pre-treatment and post-treatment photos may be viewed for educational purposes by my physician or patients; or to be sent to my insurance company for pre-approval of reconstructive procedures. Educational purposes may include: use in physician consults with individual patients, use in physician seminars presented to potential patients or medical associations and use in social media including the practice website for prospective patients.

Plastic Surgery Consultants/Advanced Plastic Surgery has my permission to use the photographs for these purposes. This consent will be in effect until physician discontinues use of these photographs. I understand that my photographs will be handled with the highest possible level of confidentiality.

Signature_____ Date _____

Printed Name_____

Race_____ Ethnicity _____ Preferred Language_____