YOUR PHOTOGRAPHS

Photograph consent *you choose each use*

FILE NO. _____

Photographs are part of planning and follow-up. They are taken before the operation and at each follow-up visit, in the same place, at the same distance, under the same lamp. Nothing is retouched. This form records what they are used for. Each use is a separate choice, and saying No to any of them does not change your care.

HOW TO FILL THIS IN Use a pen. Tick one box on each line. If you are not sure of an answer, leave it blank and ask at the clinic.

01 Your details

Full name

Date of birth (DD / MM / YYYY)

Phone / WhatsApp

Procedure

02 Where your photographs can be used

Tick Yes or No for each line.

	YES	NO
Your medical record, for planning, the operation and follow-up	☐	☐
Shown to other doctors involved in your care	☐	☐
Medical teaching and professional publications, without your name	☐	☐
The practice website, sculptedbydrvince.com	☐	☐
The practice Instagram, @dr.vincentelkhoury, and its other social media accounts	☐	☐
Advertising for the practice	☐	☐

03 How you are protected

Your name, date of birth and any other detail that identifies you are never published.

Face photographs are masked before publication. For nose and lower-face results, a black bar covers the eyes. For eyelid results, only the iris is covered. The mask never hides the treated area.

Every published photograph states the time since the operation. Before and after are cropped identically, at the same magnification. You are not paid for the use of your photographs.

	YES	NO
I agree to face photographs being published without a mask	☐	☐

PHOTOGRAPH CONSENT · CONTINUED

04 Withdrawing consent

You can withdraw any of these permissions at any time: in writing, by WhatsApp to +961 1 697 739, or at the clinic. Your photographs are then taken down from the website and from the practice's social media accounts. Copies already printed, or saved and shared by other people, cannot be recalled.

05 Signatures

Patient signature

× _____ **Date** _____

If the patient is under 18: parent or guardian, full name

_____

Parent or guardian signature

× _____ **Date** _____

FOR THE CLINIC — Witness

Clinic staff, full name

_____

Clinic staff signature

× _____ **Date** _____

Identity checked, signature confirmed in person (initials) _____ **Date** _____