PHOTOGRAPH CONSENT

Patient Name: _____

In connection with medical services which I am receiving from my physician **Dr. Behrooz Torkian** and affiliate facilities and locations.

I herby give my consent that photographs may be taken of me or parts of my body, both BEFORE and AFTER medical treatment, under the following conditions:

1. The photographs may be taken only with the consent of my physician and under such conditions and at such time may be approved by him.

2. The photographs shall be taken by my physician or by a photographer approved by my physician.

3. The photographs and negatives thereof shall be used both during and after my lifetime for medical records and for other purposes and manner as my physician deems appropriate. The photographs may be used purposes including but not limited to: treatment, research, and scientific issues.

4 In addition, with the patients' approval only such photographs and/or negatives may be used by Dr. Behrooz Torkian or his successors in interest for solicitation of business by other physicians or medical professionals and for said advertising purposes. Said photographs and negatives thereof are the exclusive property of Dr. Behrooz Torkian or successors in interest as are any profits which may be generated by the uses consented above.

5. I understand that I may be recognizable and identifiable in the photographs although reasonable attempts will be made to avoid personal identification. I hereby indemnify and hold harmless my physician, his or her employees and agents, his or her successors in interest; the photographer taking the photographs of me or parts of my body and his or her successors in interest; and Dr. Behrooz Torkian and his successors in interest. As to any claim for compensation, injury or damages resulting from activities authorized by this agreement, including without limitation publication of any or all of said photographs to which I have given my consent.

6. The aforementioned photographs and negatives may be modified or retouched in any way my physician, in his or her discretion may consider desirable.

Date:_____

Signature: _____

If signed by anyone other than patient, indicate relationship: _____