Gulf Coast
HAIR RESTORATION

Photo Release

By my authority, I do hereby give Woessner Medical Clinic/Gulf Coast Hair Restoration permission to use my photos for the following purpose (check all that apply):

_____I do not permit Dr. Woessner to use my photographs, my face exposed during consultations with prospective clients in the office.

_____I do not permit Dr. Woessner to use my photographs, my face exposed for educational purposes in seminars or through media for public understanding of baldness or hair restoration.

_____I do not permit Dr. Woessner to use my photographs, my face exposed for advertisement purposes.

Reference Release

I do not give Woessner Medical Clinic/Gulf Coast Hair Restoration permission to give my name and telephone number and/or email address to his patients wishing to call me concerning my hair transplant for reference purposes.

PATIENT NAME:_____

TELEPHONE NUMBER:_____

E-MAIL ADDRESS:_____

SIGNATURE:_____ DATE_____

WITNESS:_____ DATE_____

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www.gulfcoasthairrestoration.com