

PATIENT PHOTOGRAPHIC AUTHORIZATION, RELEASE AND DISCHARGE

1, Han	Bun-Hum	, give my consent and authorize the			
photograph(s) and/or video featuring my likeness to be published in <i>Medicine®</i> , a Wolters Kluwer publication. I understand that such imaging records may be published by <i>Medicine®</i> and/or any party acting under the license and authority of <i>Medicine®</i> in any print, visual, electronic or broadcast media, specifically including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses and Internet websites, for the purpose of informing the medical profession or the general public about plastic surgery methods, results, issues, trends, concerns and similar matters. I further understand that the imaging records shall become the property of <i>Medicine®</i> .					
I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive.					
I release and discharge <i>Medicine</i> ®, and all parties acting under their license and authority from all rights that I may have in the imaging records and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the imaging records in any medium or any claim arising from the distribution or publication by any third party.					
I hereby warrant that I am over twenty-one years of age, and competent to contract in my own name.					
I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization, Release and Discharge and fully understand its terms.					
Patient _ WITNESS	S/PHYSICIAN: SWZM &	Date			
I have read the above Authorization, Release, and Discharge. I am the parent, guardian or conservator of Hun Bun-Hum, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.					
Parent/G	Guardian	_ Date			

Medicine

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1, Lee Hany-Sub	, give my consent and authorize the					
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Patient O'R'M 10106/5	Date Date 2018 . II. 05					
WITNESS/PHYSICIAN: SUN ZW						

I have read the above Authorization, Release, and Discharge. I am the parent, guardian or conservator of

behalf and I grant this consent as a voluntary contribution in the interest of public education.

Parent/Guardian OTT H Date 2018, 11.05



PATIENT PHOTOGRAPHIC AUTHORIZATION, RELEASE AND DISCHARGE _____, give my consent and authorize the I, <u>Jeons</u> give my consent and authorize the photograph(s) and/or video featuring my likeness to be published in *Medicine®*, a Wolters Kluwer publication. I understand that such imaging records may be published by Medicine® and/or any party acting under the license and authority of Medicine® in any print, visual, electronic or broadcast media, specifically including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses and Internet websites, for the purpose of informing the medical profession or the general public about plastic surgery methods, results, issues, trends, concerns and similar matters. I further understand that the imaging records shall become the property of Medicine®. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive. I release and discharge Medicine®, and all parties acting under their license and authority from all rights that I may have in the imaging records and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the imaging records in any medium or any claim arising from the distribution or publication by any third party. I hereby warrant that I am over twenty-one years of age, and competent to contract in my own name. I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization, Release and Discharge and fully understand its terms. Patient 3720 / 3007 Date 2018.11.03 WITNESS/PHYSICIAN: Date 2018.11.03 I have read the above Authorization, Release, and Discharge. I am the parent, guardian or conservator of <u>Jeong Breong</u> - Ju, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

Parent/Guardian 7629. Date 2018. (1.03)



PATIENT PHOTOGRAPHIC AUTHORIZATION, RELEASE AND DISCHARGE , give my consent and authorize the I, NYAM SUREN photograph(s) and/or video featuring my likeness to be published in Medicine®, a Wolters Kluwer publication. I understand that such imaging records may be published by Medicine® and/or any party acting under the license and authority of Medicine® in any print, visual, electronic or broadcast media, specifically including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses and Internet websites, for the purpose of informing the medical profession or the general public about plastic surgery methods, results, issues, trends, concerns and similar matters. I further understand that the imaging records shall become the property of Medicine®. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive. I release and discharge Medicine®, and all parties acting under their license and authority from all rights that I may have in the imaging records and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the imaging records in any medium or any claim arising from the distribution or publication by any third party. I hereby warrant that I am over twenty-one years of age, and competent to contract in my own name. I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization, Release and Discharge and fully understand its terms. Patient MYGMAR SUREN (NYAMSURENDATE 2018-10-31 WITNESS/PHYSICIAN: ____ I have read the above Authorization, Release, and Discharge. I am the parent, guardian or conservator of _____, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

Parent/Guardian MYG MARSUREN Date 2018.10.31



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1, Kim.	eong - Sul	_, give my consent and authorize the		
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	d that I may refuse to sign this authorizati atment I receive.	on and such refusal will have no effect on the		
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I hereby wa	rrant that I am over twenty-one years of	age, and competent to contract in my own name.		
Patient	ove Authorization, Release and Discharge 学 점在 / 김정술 HYSICIAN: SUN 2M	e interest of public education and certify that I have and fully understand its terms. Date		
Lim Je behalf and	grant this consent as a voluntary contrib	am authorized to sign this consent on his/her oution in the interest of public education.		
Darent/Gu	ordian of MA	Date 2018.11.02		



PATIENT PHOTOGRAPHIC AUTHORIZATION, RELEASE AND DISCHARGE

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I understand th	at I may refuse to sign this authorization	on and such refusal will have no effect on the
medical treatm	ent I receive.	
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	s in any medium or any claim arising fro	om the distribution or publication by any third
party.		
I hereby warrar	nt that I am over twenty-one years of a	ge, and competent to contract in my own name.
I grant this con	sent as a voluntary contribution in the	interest of public education and certify that I have
	Authorization, Release and Discharge	
Patient 선용		Pate
WITNESS/PHYS	き SICIAN: SUN ZM ご	
I have road the	above Authorization Polesco and Dis	charge. I am the parent, guardian or conservator of
		am authorized to sign this consent on his/her
behalf and I gra	ant this consent as a voluntary contribu	ition in the interest of public education.
Parent/Guardia	an	Date