



ERIC MARIOTTI, *m.d.*  
PLASTIC AND RECONSTRUCTIVE SURGERY

## Consent for Consultation

I authorize Eric Mariotti, MD to examine and consult with me with respect to the following procedure(s) or condition(s):

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Consent for Photography (*For medical chart only*)

I, \_\_\_\_\_ consent that photographs may be taken of me or  
*Print Name*  
parts of my body by Eric Mariotti, M.D. or by a person designated by him.

Signature \_\_\_\_\_ Date \_\_\_\_\_