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_____

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