Apex Medical Spa

Dolue D Ezeanolue M.D.
1701 Bearden Dr Suite 201
Las Vegas, NV 89106

I,_____________________________________ am aware that Dr Dolue D Ezeanolue requires before and after photographs for my confidential medical records and documentation purposes. By signing this document I am granting permission to Apex Medical Spa and Dr Dolue D Ezeanolue to take before and after photographs of me for my medical records and documentation purposes.

Patients Name (print): ____

Patient Signature: ____

Date: ____

I authorize Dr. Dolue D Ezeanolue to use my (patient) photographs for the following types of media and marketing but not limited to the following:

- Print
- Visual
- Electronic
- Internet

Patient Signature: ____ Date: ____________________