AUTHORIZATION FOR RELEASE OF PATIENT PHOTOGRAPH

Name_____

Address_____

As a part of our overall evaluation of our patients, we frequently obtain pre and post operative photographs. These are used for preoperative planning, medical record documentation and educational purposes. With our consent, these photographs may be used in medical journals, textbooks, and media presentations.

I consent to the taking of photographs by Plastic Surgery Consultants (PSC) of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by PSC. I further authorize PSC to release to the American Society of Plastic Surgeons ("ASPS") such photographs.

I provide this authorization as a voluntary contribution in the interests of public educations. I understand that such photographs shall become the property of ASPS and may be retained by ASPS or released by ASPS for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to medical journal and textbooks, for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of any health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from PSC.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire ten years from the date written below.

I release and discharge PSC, ASPS, and all parties acting under their license and authority from all rights that I may have in the photographs 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 photographs.

CONSENT FOR RECORDS RELEASE

Upon scheduling your surgery, we will need to provide demographic and medical information to the facility at which the procedure is schedule. This is to ensure that all personnel involved with your care are aware of your particular medical history, including allergies to medications and diagnoses that may affect your recovery and/or treatment. This is done in accordance with hospital requirements. By signing below, you acknowledge that you allow our office to send copies of your records to the facility where you are scheduled This also allows us to provide any records needed by your insurance company or disability insurance for claims filing.

PATIENTS SIGNATURE_____DATE_____

If the patient is a minor, or cannot sign for himself, please fill out below.

SIGNATURE_____ DATE_____

RELATIONSHIP TO PATIENT_____

WITNESS_____