PHOTOGRAPHIC RELEASE AND CONSENT

I, _____, agree that Richard Wassermann, M.D., and John A. Bates, D.O. or designated representatives of the practice may take and use preoperative and postoperative photographs of my person for confidential clinical record purposes and that such photographs shall remain the property of Richard Wassermann, M.D & John A. Bates, D.O. I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

_____ _____

Patient Signature Date

In the unlikely event that I can be recognized from my photos or quotes, I understand that all reasonable steps have been taken in order to protect my identity. I understand that my photos, once posted, will be licensed to and subject to each site's terms and conditions, and may be reposted by third parties, rendering retrieval or complete deletion unachievable.

Permitted Uses. I consent to such photos and any associated quotes by me being edited and published by my Doctor in any print or electronic form, including but not limited to posts on websites and social media, for the purpose of informing my professional certifying board(s), the medical profession or the general public about medical procedures and my results, surgical or non-surgical, aesthetic or medically necessary, whether or not such settings are considered personal, educational, scientific or commercial.

Right to Revoke. I understand that I have the right to revoke this authorization in writing to my Doctor at any time, but if I do so it will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will exist for 50 years from the date written below. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from my Doctor.

Redisclosure Possible. I understand that the information disclosed, or some portion thereof, may be protected by state and/or federal law, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and I hereby waive such protections to the extent I may legally do so. I further understand that there is the potential for information disclosed under the terms of this authorization to be redisclosed by the recipient and no longer protected by HIPAA.

My Release. I release and discharge my Doctor and all parties acting under my Doctor's license and authority from all rights that I may have in the photos or quotes and from any claim that I may have relating to their use, including any claim for payment in connection with their distribution or publication.

My Approval and Consent. I certify that I have read this Authorization and Release and fully understand its terms. If I am the patient's parent, guardian or conservator, I have read this document and am authorized to consent on the patient's behalf.

_____ _____

Signature of Patient or Representative Signature of Practice Representative Witness

_____ _____

Printed Name of Patient or Representative Relationship of Representative to the Patient

Date _____