PATIENT PHOTOGRAPHIC AUTHORIZATION, RELEASE AND DISCHARGE

I consent to the taking of photographs, slides, videotapes and other images ("imaging records") by Dr. ______________________________ or his designee of me or of my likeness or parts of my body in connection with the following plastic surgery procedures(s) _________________ to be performed by Dr. ______________________________ on (Date) and (Location). I further consent to the release and transfer of copyright ownership by Dr. ______________________________ to the American Society of Plastic Surgeons ("ASPS") of such imaging records.

I understand that such imaging records may be published by ASPS and/or any party acting under the license and authority of ASPS in any print, visual, electronic or broadcast media, specifically including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses and Internet websites, for the purpose of informing the medical profession or the general public about plastic surgery methods, results, issues, trends, concerns and similar matters. I further understand that the imaging records shall become the property of ASPS.

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 which shall make my identity recognizable. Further, I recognize that in some instances the photographs may be transformed into a non-photo likeness of me.

I 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 understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Dr. _________________________________.

I understand that the information and likeness disclosed, or some portion thereof, may be protected by state law, federal law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").
further understand that, because ASPS is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA and may be redisclosed by ASPS.

I release and discharge Dr. _____________________________, ASPS, and all parties acting under their license and authority from all rights that I may have in the imaging records 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 imaging records in any medium or any claim arising from the distribution or publication by any third party.

I hereby warrant that I am over twenty-one years of age, and competent to contract in my own name.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization, Release and Discharge and fully understand its terms.

Patient _____________________________  Date _____________________________

WITNESS/PHYSICIAN: _____________________________

I have read the above Authorization, Release, and Discharge. I am the parent, guardian or conservator of _____________________________, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

Parent/Guardian _____________________________  Date _____________________________

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