authorization for and release of medical photographs/slides and/or video footage

authorization for release of patient image

Name: _____

Address: _____

(STREET ADDRESS, CITY, STATE AND ZIP CODE)

I consent to the taking of photos, sliders or video footage by Dr. Sean Simon or his designee of me or parts of my body in connection with the plastic surgery procedure's) to be performed by Dr. Sean Simon. I further authorize Dr. Sean Simon or one of his/her associates to release to the American Society of Plastic Surgeons ("ASPS") such images.

I provide this authorization as a voluntary contribution in the interest of public education. 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 journals and textbooks, for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

I hereby grant permission for the use 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.

Neither I nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the images 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 health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, from Dr. Sean Simon.

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 one year from the date written below.

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

I release and discharge Dr. Sean Simon, 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.

I certify that I have read the above Authorization and Release and fully understand its terms.

Signature: _____, Date: _____

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

Signature: _____, Date: _____