Patient Photograph and Video Release Form

I understand that photographs and/or videos may be taken of me or parts of my body before, during, and after surgery. These images may be shared with staff, other physicians or health professionals, and members of the public for educational and marketing purposes. I hereby give my consent for Dr. _____ to use the photographs under the following circumstances:

Please initial JUST ONE of the following*:*

_____I OPT OUT. I do not want my photographs to be used for advertising or marketing. They will only be used for my medical chart.

____EDUCATIONAL PURPOSES ONLY: Photographs taken of me or parts of my body as well as details regarding services that I have received may be used for scientific presentations and/or publications.

_____ALL MEDIA EXCLUDING SOCIAL MEDIA: Photographs taken of me or parts of my body as well as details regarding medical services that I have received may be used in any print or broadcast media, including but not necessarily limited to newspapers, pamphlets, educational films, practice website, and television, in order to inform and educate the public or other physicians about plastic surgery.

_____ALL MEDIA INCLUDING SOCIAL MEDIA: Photographs and/or videos taken of me or parts of my body as well as details regarding medical services that I have received may be used on social media sites, including but not necessarily limited to Facebook, Instagram, Snapchat, Twitter, RealSelf, and other outlets, in order to inform the public or other physicians about plastic surgery. I understand that once my images are published, I lose control and rights to these images. I understand that once my images are published, the individual social media platforms may assume control and rights to those images. I also understand that images posted on the Internet can be altered and/or archived, and are permanent and searchable.

_____PRACTICE WEBSITE ONLY: Photographs taken of me or parts of my body as well as details regarding medical services that I have received may be used on our website without disclosure of personal information in order to inform the public about plastic surgery methods. I understand that once these images are placed on a digital platform, they can be altered and archived, and are permanent, and searchable.

PLEASE REVIEW AND INITIAL EACH OF THE FOLLOWING:

_____REVOCATION: I understand that I may revoke this authorization at any time; however, such revocation must be in writing and received via registered mail. Revocation affects disclosure moving forward and is not retroactive.

_____EXPIRATION: This authorization expires 99 years from the date signed

_____VOLUNTARY CONSENT: I understand that my participation is voluntary. If I do not sign this form, my healthcare and payment for my healthcare will not be affected.

_____I will not receive compensation for my participation.

_____By signing this form, the personal health care information I relay or allow to be relayed to an outside source, such as social media platform or news source, is no longer protected by state and federal privacy laws and may be re-disclosed by that source.

_____I have received a copy of this consent.

_____Before signing this document, I have considered my decision carefully.

Date_____Witness_____

Patient Name _____

Patient or Guardian Signature_____