Standard Patient Photographic Consent Form

I hereby consent to the taking of photographs and/or film and sound recordings of me or parts of my body (hereinafter referred to as the "Materials") and grant NAME OF PRACTICE and/or INDIVIDUAL PHYSICIAN NAMES and/or their designee permission to publish, distribute, and otherwise use such Materials in any and all of its publications.

I understand and agree to transfer any and all rights I may have in and to these Materials, and that they will become the property of NAME OF PRACTICE and/or INDIVIDUAL PHYSICIAN NAMES and will not be returned.

I understand that the Materials may be published by NAME OF PRACTICE and/or INDIVIDUAL PHYSICIAN NAMES or a third party such as the American Society for Dermatologic Surgery in any print, visual or electronic media, specifically including, but not limited to, newspapers, magazines, medical journals and textbooks, pamphlets and the Internet, for the purpose of informing the medical profession or the general public about dermatologic surgery and/or dermatologic surgery methods.

I hereby irrevocably authorize NAME OF PRACTICE and/or INDIVIDUAL PHYSICIAN NAMES to edit, alter, copy, exhibit, publish or distribute these Materials for purposes of publicizing NAME OF PRACTICE'S services or programs or for any other lawful purpose including, but not limited to:

_____ ➢ Medical purposes related to case.

_____ ➢ Scientific purposes, including seminars, medical articles or educational presentations such as the American Society for Dermatologic Surgery Annual Meeting, website or other venue.

_____ ➢ Before-and-after photo album (digital or printed) for cosmetic patients to view in office.

_____ ➢ Before-and-after photographs and/or digital images to be included in newsletter to be sent to patients.

_____ ➢ Before-and-after photographs and/or digital images to be included in our website for cosmetic surgery.

(patient's initials)

Permission is specifically granted for the work to be edited, altered, used in whole or in part, in conjunction with other images, graphics, text and sound in any way whatsoever and without restrictions in any way that NAME OF PRACTICE and/or INDIVIDUAL PHYSICIAN NAMES or his or her designee(s) may consider appropriate to achieve the purposes for which, or comply with the limitations subject to which, this consent is given. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness or altered likeness appears. ➢ _____

(patient's initials)

I understand that the Materials may portray features that may identify or otherwise present a recognizable likeness of me.

I understand that the Materials, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Any disclosure of information carries with it the potential for an unauthorized re-disclosure, and the information may not be protected by applicable federal and/or state confidentiality rules.

_____ ➢ I understand that I may be named in a publication.
(patient's initials)

OR

_____ ➢ Neither I nor any member of my family will be identified by name without my further consent.
(patient's initials)

Additionally, I waive any right to royalties or other compensation arising from or related to the use of any Materials and understand that the copyright to all Materials is retained by NAME OF PRACTICE and/or INDIVIDUAL PHYSICIAN NAMES. The photographer shall own all Material rights, which shall accrue to the benefit of his/her successors, legal representatives and assigns. NAME OF PRACTICE and/or INDIVIDUAL PHYSICIAN NAMES need not approach me again for authorization to use these Materials.

I hold NAME OF PRACTICE and their designees harmless from any liability related to use of these Materials for the purposes outlined above.

I hereby hold harmless and release and forever discharge NAME OF PRACTICE and/or INDIVIDUAL PHYSICIAN NAMES and their designees from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons acting on my behalf or on behalf of my estate, have or may have by reason of me signing this Standard Patient Photographic Consent Form.

I am at least 18 years of age and am 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 Standard Patient Photographic Consent Form and fully understand its terms.

Signature	Date
Print Name	Date
Witness signature	Date
Witness signature	Date

If the patient signing is under 18 years of age or under any incapacity, there must be consent by the patient's conservator, guardian or health care representative as follows:

I hereby certify that I am the legal representative of_____ , named above, and do hereby give my consent without reservation to the foregoing Patient Photographic Consent Form on behalf of this person.

Representative's Signature	Relationship to Patient	Date
Witness signature		Date
Witness signature		Date