LAKEVIEW
Plastic Surgery

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PATIENT PHOTOGRAPHIC AND VIDEOGRAPHIC AUTHORIZATION AND RELEASE

I consent to the taking of photographs or video by Dr. Alison M. Shore (thereafter referred to as "my surgeon") or his/her designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by my surgeon. I understand there are different reasons for taking photographs which are described below.

I consent for photographs and video to be part of my medical record to follow my treatment plan.

I also grant permission for the use of any of my medical records including illustrations, photographs, video or other imaging records created in my case, for use in examination, certifying and/or recertifying purposes by The American Board of Plastic Surgery, Inc ("ABPS").

I understand that such photographs or video may be published in print, visual or electronic media, specifically including, but not limited to, medical journals, textbooks, lay publications, patient education materials or during lectures for the purpose of informing the medical profession or the general public about plastic surgery methods. 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. 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 the ABPS, other societies, and publishers are 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 and may be re-disclosed.

I wish to have these exclusions for use of any photographs or video: _____
_____
_____

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. 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 surgeon.

I release and discharge my surgeon and all other parties 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 grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

PATIENT SIGNATURE _____ Date _____

Printed Name _____

WITNESS SIGNATURE _____ Date _____

Printed Name _____

I have read the above Authorization and Release. I am the parent or guardian 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 SIGNATURE _____ Date _____

Printed Name _____