Pacific Dermatology INSTITUTE

Pacific Plastic Surgery and LASER CENTER

Date: _____

PATIENT PHOTOGRAPHIC AUTHORIZATION & RELEASE

I, _____ , authorize Dr. Mudge and/or our practice, and/or [his/her/their] representative(s), to take photographs, slides or videotapes of me or parts of my body for the following procedures(s) and for medical purposes to be used for my care, medical presentations and/or articles.

In addition, I authorize the use of these images, without compensation to me, for the following specific purposes: (Please initial in the boxes marked Yes or No for each item).

Yes	No	Medium
		In the office photo album for prospective patients
		In office seminars for prospective patients
		On our website for prospective patients
		In print advertisements
		On television

Additional Comments:

I understand that:

1. Such photographs, slides or videotapes may be published by Dr. Mudge and/or our practice in any print, visual or electronic media including, but not limited to medical journals and textbooks, scientific presentation and teaching courses, and internet web sites, for the purpose of informing the medical profession or the general public about plastic surgery methods. I understand that such uses may also include marketing on behalf of Dr. Mudge for which Dr. Mudge may be receive direct or indirect remuneration.
2. I will not be identified by name in any of the media described above: however, I also understand that in some circumstances the photographs, slides or videotapes may display features that identify me.
3. I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to [Privacy Officer / Responsible Person] at WHICH ADDRESS GOES HERE. A revocation shall not affect any release of information made prior to revocation in reliance upon this Authorization. If I do not revoke this authorization, it shall expire on the following date, event, or condition: [Date/Event/Condition]. If i fail to specify an expiration date, event, or condition, this authorization will expire in [State Law Dictates - Months/Years]. except to the extent action has been taken theron.
4. I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Dr. Mudge and/or our practice.
5. The information disclosed under this Authorization, or some portion therof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPPA"). Any disclosure of information may not be protected by applicable federal an/or state confidentiality rules.
6. A copy of the Authorization is valid as the original. I have received a copy of this Authorization, as provided by federal an/or state law.

I release and discharge Dr. Mudge and/or our practice from all liability, including liability for negligence, that in any way arises out of: any and all rights that I may have or may have had in the photographs, slides or videotapes of me that I have authorized to be used and disclosed in the Authorization, and any claim that I may have or may have had related to such use and disclosure of those photographs, slides or videotapes of me, including any claim for payment in connection with any distribution or publication of them in any medium. This authorization is made as voluntary condition in the interest of public education and certify that I have read this Authorization and Release carefully and fully understand its terms. If I have questions about the use or disclosure of my photographs, slides, or videotapes. I can contact [Privacy Officer / Responsible Person] at [Phone Number]

_____ _____

(Signature of Patient or responsible party) Printed Name Date