AUTHORIZATION FOR AND RELEASE OF MEDICAL PHOTOGRAPHS

Overview

This is a consent document that has been prepared to help inform you concerning permission to take photographs and to use these images for a purpose as defined within this consent document. After carefully reviewing, please sign the consent as proposed by your Medical Provider.

Medical photographs may be taken before, during, or after a surgical procedure or treatment. Consent is required to take such images. Additionally, patients may consent to release these medical photographs for a stated purpose.

Medical photography is an important part of plastic surgery and dermatology record-keeping. For most procedures, there are no faces nor identifiable marks shown, the images are stored without patient identifying data in the file names, and the practice will make every reasonable effort to obscure identifiable information like tattoos, unique jewelry or recognizable apparel in order to further deidentify any photos that might be used for publication as per the below consents.

CONSENT TO TAKE PHOTOGRAPHS

❑ I hereby authorize Dr. Sayed and/or his associates or licensees to take pre-operative, intra-operative and postoperative photographs. I additionally consent to photographs during consultations and office visits as deemed appropriate for medical record keeping. I understand these will be considered part of the medical record and may be subject to release under lawful purposes of disclosure as permitted by HIPAA privacy laws and malpractice law.

CONSENT TO RELEASE PHOTOGRAPHS

❑ I hereby authorize Dr. Sayed and/or his associates or licensees to use pre-operative, intra-operative and postoperative photographs for professional medical purposes deemed appropriate by Dr. Sayed, including, but not limited to, showing these for purposes of medical education, patient education, or during lectures to medical or lay groups.

Tim Sayed MD, P.C. Witness Initials: _____ Patient Initials: _____

CONSENT TO SHARE PHOTOGRAPHS ONLINE

❑ I hereby authorize Dr. Sayed and/or his associates or licensees to post deidentified photos on the world wide web and social media to educate other prospective patients.

❑ I will notify the practice in writing should I elect to revoke this permission in the future. I understand that if I revoke this consent in the future, the practice will initiate steps to remove the original documents from its online accounts, but that duplicates that may exist online in other locations and/or under the control of other parties may not be subject to the practice's or Dr. Sayed's ability to remove in all cases.

or

❑ I **refuse** to authorize Dr. Sayed and/or his associates or licensees to post deidentified photos on the world wide web and social media to educate other prospective patients.

_____

Patient Signature: _____

Name: _____

Relationship to Patient (If Patient is a minor or under guardianship): _____

Witness Signature: _____