Cabbabe Plastic Surgery/Plastic Surgery Consultants

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PATIENT PHOTOGRAPHIC AUTHORIZATION, RELEASE, AND DISCHARGE

I consent to the taking of photographs, slides, audio/videotapes and other images ("imaging records") by Cabbabe Plastic Surgery/Plastic Surgery Consultants or their designee of me or of my likeness or parts of my body.

I understand that the imaging records may be published by Dr. Cabbabe and/or any party acting under their license and authority of Dr. Cabbabe in any print, visual or electronic media, specifically including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses and Internet websites, for the purpose of informing the medical profession or the general public about plastic surgery methods, results, issues, trends, concerns and similar matters.

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. Further, I recognize that in some instances the photographs or audio/video files may be transformed into a non-photo likeness of me.

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 Cabbabe Plastic Surgery/Plastic Surgery Consultants.

I understand that the information and likeness disclosed, or some portion thereof, may be protected by state law, federal law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I release and discharge Cabbabe Plastic Surgery/Plastic Surgery Consultants and all parties acting under their license and authority from all rights that I may have in the imaging records 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 imaging records in any medium or any claim arising from the distribution or publication by any third party.

I hereby warrant that I am over twenty-one years of age, and 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 Authorization, Release and Discharge and fully understand its terms.

Patient ___________________________________

Date___________________________