



PLASTIC SURGERY SAN DIEGO PHOTO-VIDEO CONSENT

AUTHORIZATION FOR RELEASE OF PATIENT PHOTOGRAPHS and VIDEO

NAME _____

This consent permits photography of me or parts of my body related to the plastic surgery procedure(s) that have been or will be performed. Dr. Laverson is authorized to take these photographs and to post them as before and after pictures on his own website, plastic surgery directory websites on which Dr. Laverson maintains a presence (e.g. Realself.com, the American Society of Plastic Surgeons (ASPS) site, the American Society of Aesthetic Plastic Surgeons (ASAPS) site, and/or to distribute them in print and/or electronic media to inform prospective patients. Neither I, nor any member of my family, will be identified by name in any publication. If facial photographs are included, my identity will likely be recognizable. Jewelry, tattoos, distinctive clothing, and/or other features may also reveal my identity.

If I agree to a brief video interview after my procedure for the purpose of explaining my plastic surgery experience to others considering the procedure, such video may be posted to feelbeautiful.com, feelbeautiful.me, facebook.com/feelbeautiful, and/or the Feel Beautiful You Tube channel without my name or other identifying information, unless I myself state my name. Absolutely no video will be produced during my surgical procedure without my knowledge and express written consent.

The authorization hereby granted is voluntary, and continues until I submit a written request to Dr. Laverson withdrawing this authorization. Upon withdrawal, my photographs and/or video, in part or in total as requested by me, will be removed from any and all electronic media. Photographs released in printed form by Dr. Laverson, by ASPS, by ASAPS, or another publisher before the date of my withdrawal will not be affected by my withdrawal. Photographs printed by third parties from electronic format prior to my withdrawal will also not be affected by my withdrawal.

Photographs of me may be considered private health information. It is my right to refuse to authorize the release of my private health information. Refusal to grant consent for release of my private health information will prevent the disclosure of such information, but will never affect the quality of care I receive from Dr. Laverson. It is my right to inspect and copy all information I have authorized to be disclosed. It is also my right to revoke this authorization in writing at any time, but if I do so it won't have any affect on any actions taken prior to my revocation.

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 ("HIPAA"). I further understand that, because ASPS is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA.

I release and discharge Dr. Laverson, ASPS, ASAPS, Facebook, YouTube, Realself, and all parties acting under their license and authority 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 certify that I have read the above Authorization and Release and fully understand its terms.

Signature Date

I have read the above Authorization and Release. I am the parent, guardian, or conservator of _____, a minor. I am authorized to sign on his/her behalf and grant this authorization voluntarily.

Signature & Date