

AUTHORIZATION FOR AND RELEASE OF
MEDICAL PHOTOGRAPHS, SLIDES, DIGITAL IMAGES, AND VIDEOTAPES

INSTRUCTIONS:

This is a consent document that has been prepared to help inform you concerning permission to take photographs, slides, digital images, and videotapes and to use these images for a purpose as defined within this consent document. It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by Dr. Spring or her representative.

INTRODUCTION

Medical photographs, slides, videotapes or any other images of you, or components of your medical record, 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, slides, images, and videotapes for a stated purpose.

1. CONSENT TO TAKE PHOTOGRAPHS, SLIDES, DIGITAL IMAGES, AND VIDEOTAPES

I hereby authorize Michelle Spring, MD and or her associates or licensees to take pre-operative, intra-operative, and post-operative photographs, slides, digital images and videotapes. I additionally consent to photographs, slides, digital images and videotapes of my interview, if applicable.

Patient's Initials _____

2. CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize Michelle Spring, MD and or her associates or licensees to use pre-operative, intra-operative, and post-operative photographs, slides, digital images and videotapes for professional medical purposes deemed appropriate including but not limited to showing these images on public or commercial television, electronic digital networks, print or visual or broadcast media, for purposes of examination, testing, credentialing and/or certifying purposes, for purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups, for marketing and advertising, and for use in supporting documentation for insurance or third-party payer purposes, medical teaching, research or dissemination of medical information to medical and nonmedical audiences, including, but not limited to, journal or book publications, presentations, conferences or meetings.

I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

I understand that I will **not** be identified by name in any release of these materials but in some cases the images may contain features that may make my identity recognizable. I release and discharge Dr. Spring and all parties acting on her authority from all rights that I may have in these images, and from any claims that I have related their use in the above mentioned manner.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and /or my interview.

Patient's Initials _____

Date:

Patient Signature:

Witness: