Patient:

# PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I, _____, authorize New Leaf Plastic and Reconstructive Surgery, Dr. Lovelace, and or their representative(s), to take photographs, slides or videotapes of me or parts of my body for the following procedure(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 **websites** for prospective patients. |
| | | in print **advertisements**. |
| | | on **television**. |
| X | | In **personal chart** and for **board certification** purposes. |
| Additional Comments: | | |

I understand that:

1. Such photographs, slides or videotapes may be published by Dr. Lovelace and/or New Leaf Plastic and Reconstructive Surgery in any print, visual, or electronic media including, but not limited to, medical journals and textbooks, scientific presentations 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. Lovelace , for which Dr. Lovelace may 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 refuse to sign this authorization.

4. The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by applicable federal and/or state confidentiality rules.

Patient:

5. A copy of this Authorization is valid as the original. I have received a copy of this Authorization. I may inspect or copy information to be used or disclosed under this authorization, as provided by federal and/or state law.

I release and discharge Dr. Lovelace and/or New Leaf Plastic and Reconstructive Surgery 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 this Authorization; and

- any claim that I may have or may have had relating 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 a voluntary contribution in the interest of public education and I certify that I have read this Authorization and Release carefully and fully understand its terms.

New Leaf Plastic and Reconstructive Surgery will make every effort they can to hide your identity when your photos are used for the purpose authorized above. In some cases this is not possible such as when the procedure is performed on the face. Otherwise, we will make every effort not to include your face or tattoos that could identify you in your photos. We will also make every attempt to erase any identifying data from the picture files that are saved to the website as well. If I have questions about the use or disclosure of my photographs, slides, or videotapes, I can contact **Dr. Candis Lovelace** at 817-380-1087

_____ is a minor, and we, the undersigned, are the parents or legal guardian of him/her and do hereby have legal authority to consent and do consent for him/her.

Signature _____ Date _____

Witness _____