Fadi C. Constantine, M.D., P.A.

Authorization for release of Patient Photography

Patient Name____

Address____
(Street address, City, State, and Zip code)

I consent to the taking of photographs or video by Dr. Constantine or their designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Constantine. I further authorize Dr. Constantine or one of his/her associates to release to the American Society of Plastic Surgeons® (“ASPS®”) such photographs.

I provide this authorization as a voluntary contribution in the interests of public education. I understand that such photographs shall become the property of Dr. Constantine and may be retained by Dr. Constantine or released by Dr. Constantine for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals, textbooks, or Web sites for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

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 that will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information but will not affect the health care services I presently receive, or will receive, from Dr. Constantine.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further 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 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 Dr. Constantine 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. Constantine, ASPS, 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 this authorization on his/her behalf, and I give this authorization as a voluntary contribution in the interest of public education.

________________________________ ________________________________
Signature Date