



Patient Photographic Authorization and Release

I, _____, (please check one of the following)

authorize **do not authorize** Dr. Hall and/or Hall Plastic Surgery & Rejuvenation Center, and/or his/their representative(s), to take photographs, slides or videotapes of me or parts of my body showing before and after results of procedure(s). In addition, I authorize the use of these images, without compensation to me, to be used in the office, for office seminars, on websites owned by or operated on behalf of Hall Plastic Surgery & Rejuvenation Center for prospective patients, in print advertisements, medical presentation, articles, and on television. (This acknowledgement does not pertain to photographs, slides, or videotapes required for medical charts and/or records.)

I understand that:

1. Such photographs, slides or videotapes may be published by Dr. Hall and/or Hall Plastic Surgery & Rejuvenation Center 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 the behalf of Dr. Hall, for which Dr. Hall 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 revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to Tricia Hall (Privacy Officer). A revocation shall not affect any release of information made prior to revocation in reliance upon this authorization.
4. I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Dr. Hall and/or Hall Plastic Surgery & Rejuvenation Center.
5. The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or the federal Health Information 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.
6. A copy of this Authorization is valid as the original. 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. Hall and/or Hall Plastic Surgery & Rejuvenation Center from all **photographic liability**, including **photographic 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 had relating to such use and disclosure of those photographs, slides or video tapes 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.

Patient is a minor, _____ years of age, and we, the undersigned, are the parents or guardian of the patient and do hereby consent for the patient.

Signature: _____ Date: _____

Printed Name: _____