PATIENT PHOTOGRAPH AND INFORMATION RELEASE FORM

Patient's Name_____ Date:_____

I hereby acknowledge that I have been advised that photographs will be taken of me before and after medical services are provided to me at _____ (the "Practice"). The photographs will be taken by one of the members of the Practice staff. I hereby give my consent for the Practice to take photographs of me and use the photographs as well as the fact that I have received medical services (including the type of medical services I have received) at the Practice in any print or broadcast media, including but not necessarily limited to newspapers, pamphlets, educational films, the Practice's internet site and television, in order to inform the public about our Practice's medical services.

Federal and state laws protect the personal health information disclosed pursuant to this Authorization. I understand that if the authorized recipient of the information is not a healthcare provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected. I release and discharge the Practice and its employees, officers and agents acting under their license and authority from any and all claims or actions that I have or may have relating to such use and publication and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment in connection with any such use or publication.

This authorization will expire upon the expiration of twelve (12) months following the date below. I understand that I have the right to revoke this Authorization at any time, and in order to do so, I must present a written revocation to you. I understand that the revocation will not apply to information that already has been released in response to or in reliance upon this Authorization. I understand that I need not sign this Authorization in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility benefits. I understand that if this authorization is sought by a covered entity I will be given a copy of this Authorization form, after signing it.

Signature of Patient/Authorized Representative (include relationship or nature of authority)

_____(LS)
Signature

_____
Print Name

Date_____

Witness_____

Patient or Guardian Signature_____