

**CONNALL COSMETIC SURGERY
PATIENT PHOTO AUTHORIZATION AND RELEASE**

I, _____ consent to the taking of photographs or videotapes (including using digital media) of me or parts of my body, by Timothy P. Connall, M.D. and/or his designee(s), in connection with the evaluation of and possible performance of plastic surgery procedures, by Timothy P. Connall, M.D. and/or his designee(s). I understand that such photographs, videotapes or case histories are needed for my medical record for evaluation and medical documentation.

I understand that in some cases Timothy P. Connall, M.D. may wish to use such photographs, videotapes or case histories of me in print, visual or electronic media (including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, books, magazines and Internet web sites) for the commercial, non-profit and/or educational purpose of informing the medical profession or the general public about plastic surgery methods. In addition, Dr. Connall may wish to show, and possibly transmit via e-mail, such images to others physicians for consultative purposes.

- I understand that 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 shall make my identity recognizable.
- I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire twenty (20) years from the date written below.
- I understand that I may refuse to sign this authorization and such refusal will have no effect on my initial consultation with Dr. Connall.
- 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 understand that the photos, films or videos of me are the property of Timothy P. Connall, M.D., and that upon request with my signature, I may obtain a copy.
- Details of photographing/filming/videotaping have been explained to me in terms I understand.
- Dr. Connall and/or his designee(s) have answered all of my questions to my satisfaction.

Patient Initials

Connall Cosmetic Surgery
PATIENT PHOTO AUTHORIZATION AND RELEASE

1. _____ I agree and authorize the taking of photos, film or video of me for medical evaluation and documentation purposes.

_____ I DO NOT authorize the taking of photos, film or video of me for medical evaluation and documentation purposes.

2. _____ I agree and authorize the use of the photos, film or video of me for consultative purposes with other physicians, including transmission and communication via e-mail.

_____ I DO NOT authorize the use of the photos, film or video of me for consultative purposes with other physicians, including with communication and transmission via e-mail.

3. _____ I agree and authorize use of the photos, film or video of me for teaching purposes, which include being shown to other patients. *I am aware that my name and identity will not be disclosed.*

_____ I DO NOT authorize the use of these photos, film or video for teaching.

4. _____ I agree and authorize use of the photos, film or video of me in the advertisements of Timothy P. Connall, M.D. *I am aware that my name and identity will not be disclosed*

_____ I DO NOT authorize the use of these photos, film or video for advertising.

5. _____ I agree and authorize Timothy P. Connall, M.D. to place my photos, film or video on his professional web site. *I am aware that my name and identity will not be disclosed.*

_____ I DO NOT authorize the use of these photos, film or video for advertising.

I release and discharge Timothy P. Connall, M.D., and all parties acting under his authority from all rights that I may have in the photographs, videotapes or case histories 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 these materials in any medium.

I grant this consent voluntarily, certify that all blanks were filled in prior to my signature and certify that I have read the above Authorization and Release and fully understand its terms.

Patient

Date

WITNESS/PHYSICIAN: _____

I have read the above Authorization and Release. I am the parent, guardian or conservator of _____, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntarily.

Patient/Guardian

Date