Plastic Surgery Center

David H. Humphreys, M.D.
5 Livingston Street ◆ Asheville NC 28801

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

Patient: ____ Date: ___________________________

Dr. David H. Humphreys, may disclose protected health information in the form of photographs, films, and/or videos from the records of ____.

I understand that photographs are a necessary part of my medical record. Such photographs, slides, or videotapes may be published by David H. Humphreys, M.D., 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 David H. Humphreys, M.D., for which he may receive direct or indirect remuneration.

I agree and authorize the use of these images, without compensation to me, for the following specific purposes:
(Please initial in the boxed marked Yes or No for each item)

Yes	No	Medium
		Office **medical record. (Required)**
		In office **seminars** for prospective patients.
		On our **website** for prospective patients.
		In print **advertisements.**
		In the office **photo album** for prospective patients.

Additional Comments:

I understand that the images will not be identified by name but that such photographs, videotapes, computer, and/or Internet images may reveal my identity (i.e. facial shots, distinctive body markings). I accept this loss of anonymity.
I understand that I have the right to revoke this authorization, ***in writing***, at any time by sending such written notification to the practice at 5 Livingston Street, Asheville, NC, 28801.
I understand that a revocation is not effective to the extent that my physician has already disclosed the health information.
I understand that information released by this authorization may be disclosed by the recipient and may no longer be protected by federal and state law.

______________________________________ ______________________________________
Patient Signature Date Witness Signature Date