forma
PLASTIC SURGERY

AUTHORIZATION TO RELEASE MEDICAL IMAGING RECORDS

I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery. This consent includes photos/images taken at the time of my original consultation as well as photos/images taken during treatment received in the hospital or surgery center.

This authorization is provided as a voluntary contribution in the interests of public education. I understand that such imaging records shall become the property of American Society of Plastic Surgery (ASPS) and may be retained by ASPS or released by ASPS for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals and textbooks, for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

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 ASPS 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. Neither I, nor any member of my family, will be identified by name in any publication, but I understand that in some circumstances, the images may portray features that will make my identity recognizable.

I authorize the release of my imaging records to be used without compensation for the purposes of advertising in our office photo album and in office seminars for prospective patients. These imaging records may also posted on our website or be used in print or television advertising.

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 Beautologie Scottsdale. In addition, I understand that I have the right to inspect and copy the information that I have authorized to be disclosed.

I release and discharge Arizona Plastic & Reconstructive Surgeons, PLLC dba Forma Plastic Surgery and all parties acting under their license and authority from all rights that I may have in the imaging records 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 imaging records.

I understand that 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 Forma Plastic Surgery at PO Box 60610, Phoenix, AZ 85082. A revocation shall not affect any release of information made prior to revocation in reliance upon this authorization.

I certify that I have read the above Authorization and Release and fully understand its terms.

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

_____ _____

Witness Signature Date