

AUTHORIZATION FOR RELEASE of PATIENT PHOTOGRAPHS

I consent to the taking of photographs by Dr. John Rowley, or his designee, of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. John Rowley. I further authorize Dr. John Rowley, to utilize these photographs in the interests of public education and for practice marketing purposes.

I provide this authorization as a voluntary contribution and I understand that such photographs shall become the property of Dr. John Rowley, and may be retained by or released by Dr. John Rowley *for* the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, before and after portfolio of photographs (**both hard copy and website**), for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

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 will make my identity recognizable.

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 Dr. John Rowley.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire ten years from the date written below.

I release and discharge Dr. John Rowley and all parties acting under his license and authority, from all rights that I may have in the photographs 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 photographs.

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

Signature

Date

I have read the above Authorization and Release. 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 and for practice marketing.

Signature

Date

I certify that I have read the above Authorization and Release and fully understand its terms and **do not wish** to have my photographs used as described above.

Signature

Date