cma | Center for Modern Aesthetic Medicine

Consent for Photography & Authorization to Release

I, _____, as the patient identified above or the legal representative of such patient ("**Patient**"), have consented to the taking of photographs, videotapes, digital or audio recordings, and/or images of Patient, and any other method to reproduce or edit such Patient's likeness or image now known or hereafter developed (collectively, "**Photography**"), by the Center for Modern Aesthetic Medicine (CMA Medicine) and its staff. I understand that such Photography will be recorded to document and assist with the patient's care and to assist with health care operations. Refusal to consent to Photography will in no way affect the medical care provided by CMA medicine. I also understand that the Photography that identifies Patient can be released and/or used outside CMA Medicine only upon written authorization from me.

CMA Medicine desires to utilize the Photography for purposes of professional publications, training, education or clinical evaluation, and including such Photography in CMA Medicine's print and email marketing both of which will result in the publication and distribution of protected health information to the public. CMA Medicine is NOT receiving direct or indirect remuneration from a third party in connection with the use/disclosure of the protected health information described in this authorization.

Please Initial:

____ I authorize CMA Medicine to use Patient's Photography for purposes of professional publications, training, education, and clinical evaluation. In addition, I understand that the Photography may incidentally disclose additional protected health information related to Patient's treatment, condition, procedure, or other protected health information associated with the Photography, and I authorize such disclosure.

____ I authorize CMA Medicine to use Patient's Photography in its print and email marketing campaigns. In addition, I understand that the Photography may incidentally disclose additional protected health information related to Patient's treatment, condition, procedure, surgery or other protected health information associated with the Photography, and I authorize such disclosure.

____I understand the Photography will become part of the Patient's medical record and therefore protected, used and/or disclosed in accordance with CMA Medicine's Notice of Privacy Practices. I understand that CMA Medicine will own the Photography and I will not receive any payment for such Photography, but that I will be allowed to access or view them or to obtain copies of them as part of the Patient's medical record.

_____I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to CMA Medicine's Privacy Officer. I understand that a revocation is not effective to the extent that CMA Medicine has relied on the use or disclosure of the protected health information. I understand that, except as otherwise provided in this authorization, CMA Medicine may use or disclose my protected health information in accordance with CMA Medicine's Notice of Privacy Practices. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or other applicable laws or regulations. I release and hold harmless CMA Medicine its officers, staff and employees from all claims or causes of action that I may have of any nature whatsoever, which may in any manner result from the use of the Photography. I understand that CMA Medicine will not condition my treatment, payment or eligibility for benefits on whether I provide authorization for the requested use.

I have read this consent in its entirety and agree to be bound by all of its terms and conditions as described above. I acknowledge and agree that I have been given the opportunity to ask any questions and had all my questions answered to my satisfaction.

Patient Name (Printed): _____

Patient Signature (Or Patient's Legal Representative): Date: ___