PATIENT PHOTO CONSENT
(HIPAA-compliant)

Permitted Users. I, the undersigned patient, consent to photographs, recordings and/or videos, by any medium in existence (hereinafter "photos") being taken of me during the below-identified procedure(s), which may be used by MED ABOUT YOU, LLC and/or any party or entity acting under his/her license and authority, including but not limited to MED About You (all such users hereinafter collectively referred to as "my provider"):

Permitted Uses. I consent to such photos and any associated quotes by me being edited and published by my Provider in any print or electronic form, including but not limited to posts on websites and social media, for the purpose of informing my professional certifying board(s), the medical profession or the general public about medical procedures and my results, surgical or non-surgical, aesthetic or medically necessary, whether or not such settings are considered personal, educational, scientific or commercial.

I expect to be recognized from my photos or quotes.
I understand that my photos, once posted, will be licensed to and subject to each site's terms and conditions, and may be reposted by third parties, rendering retrieval or complete deletion unachievable.

Right to Revoke. I understand that I have the right to revoke this authorization in writing to my Provider 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 autho-rization, it will exist for 50 years from the date written below. I understand that I may refuse to sign this authori-zation and such refusal will have no effect on the medical treatment I receive from my Provider.

Redisclosure Possible. I understand that the information disclosed, or some portion thereof, may be protected by state and/or federal law, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and I hereby waive such protections to the extent I may legally do so. I further understand that there is the po-tential for information disclosed under the terms of this authorization to be redisclosed by the recipient and no longer protected by HIPAA.

My Release. I release and discharge my Provider and all parties acting under my Provider's license and authority from all rights that I may have in the photos or quotes and from any claim that I may have relating to their use, including any claim for payment in connection with their distribution or publication.

My Approval and Consent. I certify that I have read this Authorization and Release and fully understand its terms. If I am the patient's parent, guardian or conservator, I have read this document and am authorized to consent on the patient's behalf.

_____ _____
Patient/Parent-Guardian-Conservator Signature Print Name & Date

_____ _____
Witness / My Provider Signature Print Name & Date

REVOKATION NOTICE

_____
METHOD/ RECEIVED DATE *NAME OR INITIALS*