Clinique Dallas
PLASTIC SURGERY
MEDSPA & LASER CENTER

PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I authorize Clinique Dallas Plastic Surgery and/or its representative(s), to take photographs, slides or videotapes of me for medical purposes to be used for my care, medical presentations, surgery planning, or as educational material for future patients.

In addition, I authorize the use of these images, without compensation to me, for the following specific purposes:

YES	NO	MEDIUM
		in the office **photo album** for prospective patients.
		in office **seminars** for prospective patients.
		on our **website** for prospective patients.
		in **print advertisement.**
		In **social media** *(Facebook, Twitter, Instagram, etc)*
		In **our publications** *(Body of Courage, InSight Magazine).*
Additional Comments:		

I understand that:

1. Such photographs, slides or videotapes may be published by Clinique Dallas Plastic Surgery. 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 plastic and reconstructive surgery. I understand that such uses may also include marketing on behalf of Clinique Dallas.

2. I will not be identified by name in any of the media described above; however, I also understand that in some circumstances the photographs, slides, or videotapes may display features that identify me (only on procedures that involve face and eyes).

3. 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 Clinique Dallas at 7777 Forest Ln Suite C-230 Dallas, TX 75230; revocation shall not affect any release of information made prior to revocation in reliance upon this Authorization.

4. I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Dr. Antonetti.

5. The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by applicable federal and/or state confidentiality rules.

6. A copy of this Authorization is valid as the original. I have received a copy of this Authorization. I may inspect or copy information to be used or disclosed under this authorization, as provided by federal and/or state law.

I release and discharge Clinique Dallas and its doctors from all liability, including liability for negligence, that in any way arises out of:

- any and all rights that I may have or may have had in the photographs, slides or videotapes of me that I have authorized to be used and disclosed in this Authorization; and
- any claim that I may have or may have had relating to such use and disclosure of those photographs, slides or videotapes of me, including any claim for payment in connection with any distribution or publication of them in any medium.

This Authorization is made as a voluntary contribution in the interest of public education and I certify that I have read this Authorization and Release carefully and fully understand its terms.

If I have questions about the use or disclosure of my photographs, slides, or videotapes, I can contact Clinique Dallas at (972) 566-2010.

If the patient is a minor, the undersigned, are the parents or legal guardian of them and do hereby have legal authority to consent and do consent for them.

Signature: _____ **Witness:** _____ **Date:** _____