

**PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE**

I consent to the taking of photographs by Bryan S. Armijo, MD or his designee of me or parts of my body in connection with the plastic surgery procedures(s) to be performed by Bryan S. Armijo, MD. 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, Inc (ABPS).

I understand that such photographs may be published by Dr. Armijo 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 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 which shall make my identity recognizable.

I 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. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Bryan S. Armijo, MD.

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/ABPS 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 and may be redisclosed by ASPS/ABPS.

I release and discharge Bryan S. Armijo, MD, ASPS/ABPS, and all parties acting under their 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 grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

*Patient* \_\_\_\_\_ *Date* \_\_\_\_\_

WITNESS/PHYSICIAN: \_\_\_\_\_

I have read the above Authorization and Release. I am the parent, guardian or conservator of \_\_\_\_\_, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

*Parent/Guardian* \_\_\_\_\_ *Date* \_\_\_\_\_