MR# __________

Patient Photographic Consent, Authorization, & Release

- I consent to the taking of photographs, digital imaging or video footage by Rau Plastic Surgery, LLC of me or parts of my body in connections with procedure(s) to be performed by this practice.
- I certify my understanding that there is no warranty, expressed or suggested, as to my own final appearance after surgery by the use of electronically altered images.
- I provide this authorization as a voluntary contribution in the interests of public education. I understand that such photographs shall become property of Rau Plastic Surgery, LLC and may be retained of released for the limited purpose of:

_____ Personal Viewing (Patient, Physician, and Nurse Only)
_____ Before & After Photo Book in Dr. Rau's Consultation Room
_____Medical publications/representation
_____Digital presentations for medical education purposes
_____Research or marketing including social media, radio, & television
_____Website (www.rauplastics.com)
_____Medical Seminars, symposiums, or events suitable for patient education
_____Other(Specify)_________________________________
_____I give my permission to disclose my name with the use of my testimonial

- 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 any provider from Rau Plastic Surgery, LLC.
- 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 will not have any effect on any actions taken prior to my revocation. Unless otherwise revoked, this authorization will expire in 5 years.
- Re-disclosure. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
- 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 ("HIPPA").
- I release and discharge Rau Plastic Surgery, LLC 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 in publication, including and claim for payment in connection with distribution or publication of the photographs.

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

I understand that I will receive a copy of this signed authorization.

Patient or Guardian (if minor) Signature Date

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