



**CAPITAL CITY
COSMETIC SURGERY**

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Authorization for Release of Patient Photographs

Patient Name:

DOB:

I consent to the taking of photographs by Dr. Dorner or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Dorner. These photographs are necessary for complete medical documentation.

I further understand that such photographs shall become the property of Dr. Dorner and may be retained by Dr. Dorner. I give consent for the photographs to be released by Dr. Dorner specifically including, but not limited to, the following purposes (**PLEASE CROSS OUT THOSE AREAS FOR WHICH YOU DO NOT GIVE CONSENT**):

1. Examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.
2. Patient examples in printed materials, visual or electronic media, internet websites, direct mailings, brochures, etc. to be viewed by perspective patients.
3. Use in advertising including, but not limited to, printed materials, visual or electronic media, internet websites, direct mailings, brochures, etc.
4. Educational seminars, scientific meetings, or published papers in both the scientific literature and popular presses.

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 that will make my identity recognizable.

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 Dr. Dorner.

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 won't have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will remain in effect in perpetuity.

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 Dr. Dorner 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.

I release and discharge Dr. Dorner, and all parties acting under his 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 certify that I have read the above Authorization and Release and fully understand its terms.

Signature

Date

I have read the above Authorization and Release. I am the parent, guardian, or conservator of _____ . I am authorized to sign this authorization on his/her behalf and I give this authorization voluntarily.

Signature

Date