EARL GAGE, MD
BOARD CERTIFIED PLASTIC SURGEON

Photography Consent

Patient Name _____ DOB _____
Address _____
_____
(street address, city, state and zip code)
Email Address _____
Phone Number _____

I consent to the taking of photographs by Dr. Earl Gage or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Gage.

I provide this authorization as a voluntary contribution in the interests of public education. I understand that such photographs shall become the property of Dr. Earl Gage and may be retained by Dr. Gage or released by Dr. Gage for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals, textbooks, brochures or web sites for the purpose of informing the medical profession or the general public about plastic surgery procedures and 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 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. Earl Gage.

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 expire ten years from the date written below.

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 release and discharge Dr. Earl Gage 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 explicitly authorize Dr. Earl Gage to use my photos for the following purposes (please initial):

___ Informational brochures
___ Websites
___ Medical journals, textbooks
___ Printed advertisements
___ Electronically distributed advertisements

I certify that I have read the above Authorization and Release and fully understand its term.

_____ _____
Patient Print Name Witness Print Name

_____ _____
Patient Signature Date Witness Signature Date