DR BRIAN BUINEWICZ
plastic surgery + wellmed spa

AUTHORIZATION FOR RELEASE OF PATIENT IMAGE

Name:_____

I consent to the taking of photos, slides or video footage by Dr. Buinewicz or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Buinewicz or his staff.

I provide this authorization as a voluntary contribution in the interests of public education. I authorize the use of these images, without compensation to me for the following specific purposes:

□ **in the office electronic photo album for prospective patients _____(initials)**

□ **in office seminars for prospective patients _____(initials)**

□ **on our website for prospective patients _____(initials)**

□ **on social media platforms _____(initials)**

□ **in print advertisements _____(initials)**

□ **on television _____(initials)**

□ **in educational journals or educational seminars and presentations _____(initials)**

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the images 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.Buinewicz or his staff.

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 affect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire one year 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. Buinewicz, his staff 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 certify that I have read the above Authorization and Release and fully understand its terms.

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

Signature_____ _____ _____ _Date_____

Witness_____