**THIS TEMPLATE IS PROVIDED AS A MATTER OF CONVENIENCE – ASPS MAKES NO REPRESENTATIONS REGARDING ITS COMPLIANCE WITH STATE OR FEDERAL LAW.

 ___Patient Initials

I, _____, permit Dr. _____ ("**my surgeon**") or his/her designee to take photos and/or videos before, during, and after my surgery. These may be of me or parts of my body ("**my images**"). I agree that my surgeon can share them with staff, other health professionals, and the public. This may be done for educational or marketing purposes.

I understand that once my images are published, I lose control over their use. I have no control over where they are published. I agree to give up certain rights to my image. I release any claim I may have to the publication of such images. This includes any payment for their distribution.

I understand that images posted online may be saved. They may be available forever. They may be found in online searches. I realize that people may repost my images without my surgeon's consent. This may be used in social media. Neither I nor my surgeon have any control over this. I agree that my surgeon is not responsible for third-party use. I release my surgeon from any claim that might arise from this use.

I agree that my surgeon can use my images in the following context:

Please initial <u>ONLY ONE</u> of the following

_____ALL MEDIA: My images and medical details may be used in print and broadcast media. This includes newspapers, pamphlets, educational films, the internet (including social media and applications), and television.

_____WEBSITE ONLY: My images and medical details may be used on my surgeon's website.

_____ ALBUM ONLY: My images and medical details may be used in printed and/or digital photograph albums. The albums will only be used to show other patients my surgeon's methods.

(Signature Page Follows)

I agree to the educational use of my images. I have fully read and understand the above terms. I have made my decision carefully and understand the risks.

PATIENT SIGNATURE: _____ Date: _____

Printed Name: _____

WITNESS SIGNATURE: _____ Date: _____

Printed Name: _____

For patients under the age of 18:

I, the parent or guardian of _____, a minor, am authorized to sign this release on his or her behalf. I agree to the educational use of his or her images.

PARENT/GUARDIAN SIGNATURE: _____ Date: _____

Printed Name: _____

 _____**Patient Initials**