Wally Hosn, M.D.
Plastic Surgeon

Photography Consent

Patient Name: _____ D.O.B.: _____

It is standard procedure for Dr. Hosn and/or his staff to take pre and postoperative photographs of his patients. The undersigned hereby authorizes Wally Hosn, M.D. and/or the staff of the Aesthetic Plastic Surgery Center to be photographed while under the care of Wally Hosn, M.D.

- I agree to have both pre and postoperative photos taken for my record and for patient education purposes. My name will not be used on any such photographs. I understand the photos are the property of Wally Hosn, M.D.

- I hereby grant permission any and all purposes including, but not limited to: care, advertising, promotional, educational and medical office books, scientific presentations and teaching courses and in all media, including electronic, digital and print media and further consent to the release of such photographs, videotapes or case histories for the purpose of informing the medical profession or the general public about plastic surgery methods.

- I hereby consent to the above, without expectation of remuneration to me now or in the future, and that such use is subject only to the following limitations:
    - Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances that the photographs may portray features that shall make my identity recognizable.
    - 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 understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire twenty years from the date written below.

_____ _____
Patient or Legal Guardian Date

_____ _____
Witness Relationship