**AUTHORIZATION FOR RELEASE OF PATIENT PHOTOGRAPH**

Name _____

Address (street, city, state, & zip)_____

I consent to the taking of photographs by Dr. Kirbo, Dr. Rosenberg or their designee, of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Kirbo or Dr. Rosenberg. I further authorize Dr. Kirbo or Dr. Rosenberg or one of his/her associates to release to the American Society of Plastic Surgeons ("ASPS") such photographs.

I provide this authorization as a voluntary contribution in the interests of public education. I understand that such photographs shall become the property of ASPS and may be retained by ASPS or released by ASPS for the limited 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. Kirbo or Dr. Rosenberg.

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 ten years from the date written below.

I hereby grant permission for the use of any of my medical records, including illustrations, photographs, or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

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

_____ _____

Patient Signature Date

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.

_____ _____

Guardian Signature Date

_____ _____

Witness Date

Physician Initials _____