PLASTIC SURGERY
NORTHWEST

PHOTO AND VIDEO CONSENT AND AUTHORIZATION

Agreement for capture, disclosure and use of still photos, moving video and computer images.

I,____, authorize the capture, disclosure and use, as noted below, of photographs, video and **accompanying protected health information** related to my healthcare services at Plastic Surgery Northwest ("Media"). I understand that my photo will be taken and placed in my permanent medical record.

Media may also be used or disclosed for:

Y	N	
☐	☐	Photo albums for the education of Plastic Surgery Northwest patients
☐	☐	Publication in print or visual media, including medical journals, textbooks, educational videos, or presentations
☐	☐	Publication on the Plastic Surgery Northwest website, social media platforms, or in other advertising media representing and/or marketing Plastic Surgery Northwest and its services and physicians

Published Media may include my image, voice, age, sex, medical condition, treatment, and outcome, but this consent does not authorize the release of written or printed medical records. However, please withhold the following specific information:

Please list any identifying marks (including tattoos, birthmarks etc.) that you would like removed from the images. No corrections will be made that will alter the appearance of actual surgical results.

All Media will become the property of Plastic Surgery Northwest and may be retained for the purposes and uses approved in this consent. I understand that Plastic Surgery Northwest may receive compensation for its use and/or disclosure of Media in marketing materials such as websites, media outreach, brochures, television, and/or any other media outlets or for other marketing purposes. I understand and agree that I will not receive any compensation for use of Media, and I waive any right for myself, my spousal community or my heirs and assigns to receive any compensation. I agree to hold harmless Plastic Surgery Northwest and its associated physicians and any and all employees from all claims and liabilities whatsoever in law and in equity arising from disclosure and use of Media as authorized in this consent.

I understand that I may refuse to authorize the disclosure and use of any Media and that my refusal to consent will prevent its disclosure and use except solely in connection with healthcare services at Plastic Surgery Northwest, but such refusal will not affect the healthcare services that I receive from Plastic Surgery Northwest. I understand that I have the right to revoke this authorization in writing at any time, but I further understand that revocation will not apply to or cause the retraction of previously published, disclosed or used Media.

I hereby grant permission for the use of any 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.

By signing below, I acknowledge and certify that I have read, understood, and agreed to the terms of this consent, and that I have received a copy of the signed consent.

____

Patient Name Date of Birth

____

Patient / Guardian Signature Date