cosmetic surgery
AFFILIATES
educated • experienced • sincere

CONSENT FOR PHOTOGRAPHY

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

I provide this authorization as a voluntary contribution in the interests of public education. I understand that such photographs shall become the property of Cosmetic Surgery Affiliates (CSA) and may be retained by CSA or released by CSA for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, websites, medical journals and textbooks, for the purpose of informing the medical profession or the general public about cosmetic 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 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. Nuveen.

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. Nuveen, CSA, 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

1. _____ I authorize CSA, its employees, and associates to digitally record me via photograph and video, and create reproductions of such digital images for my medical record. This authorization includes all photographic and digital images of any part of my body.

2. _____ I authorize CSA the use of my photographs and digital images for medical research, patient education, and media purposes. Such photographs and digital images may be published in professional journals, medical books, advertisements, websites, or any other purpose that Dr. Erik Nuveen deems appropriate in the interest of medical education, patient education, and media. It is specifically understood that in any such publication or use, I shall not be identified by name. I understand that such identification is never intentional, but could possibly occur. I certify that I have read the above Authorization and Release and fully understand its terms.

_____ _____

Signature/Guardian of Minor Date