GALLAHER
GALLAHER PLASTIC SURGERY & SPA MD

Authorization for the Use of Patient Information and Photographs

Patient Name: _____ **Chart # _____**

I, _____ (name), understand that this Authorization permits photography of me or parts of my body related to the plastic surgery procedure(s) that have been or will be performed and authorizes the disclosure of my photographs for past, present and future periods of treatment.

I hereby expressly authorize Gallaher Plastic Surgery & Spa MD, its employees, agents, and assignees the right to photograph me and use my photograph(s), physical likeness, and other reproduction(s) of my likeness in publications, examination, testing, marketing, certification, and on the Gallaher Plastic and Reconstructive Surgery internet site photo gallery. I further understand that such use includes disclosure of my photographs to the general public and other third parties.

I understand that pursuant to this Authorization, Gallaher Plastic Surgery & Spa MD, its employees, agents, and assignees may use my likeness for informational, marketing, educational and/or commercial purposes.

Please check and initial one of the following:

- ☐ ____ (initials). I **authorize** Gallaher Plastic Surgery & Spa MD to use my name or other identifying information along with my photographs for the purposes and in the manner discussed in this Authorization.
- ☐ ____ (initials). I **do not authorize** Gallaher Plastic Surgery & Spa MD to use my name or other identifying information in association with my photographs. By checking this box and initialing here, I understand that while Gallaher Plastic Surgery & Spa MD will take reasonable steps to ensure that my name is not associated with my photographs used under this Authorization, Gallaher Plastic Surgery & Spa MD cannot be held responsible for the errors or omissions of third parties, or circumstances created by technology, that could nevertheless render my photographs identifiable. By checking this box and initialing here, I further acknowledge the possibility that I may be identified photographically because of my own unique physical features, tattoos, or other means visible in my actual photographs used under to this Authorization.

I understand that I may refuse to authorize the release of the health information discussed herein, including photographs, and that my refusal will prevent the disclosure of such information, other than as permitted to carry out treatment, payment or health care operations under 45 C.F.R. § 164.506. I further understand that such refusal will not affect the health care services I presently receive or will receive from Gallaher Plastic Surgery & Spa MD.

This Authorization is voluntary, and if not revoked by me, will expire upon receipt of written notification of my death or written revocation in writing, whichever occurs first. I understand I may revoke this Authorization in writing at any time. I also understand that any revocation made by me will not affect any actions taken prior to my revocation and that information disclosed under this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I hereby certify and represent that I have read the foregoing and fully understand its meaning and effect and intend, through my signature, to be legally bound.

Signature: _____ **Date:** _____

Witness: _____