GALLAHER
GALLAHER PLASTIC SURGERY & SPA MD

I, _____, permit Gallaher Plastic Surgery & Spa MD, its employees, agents, and/or any party or entity acting under its license and authority (collectively, the "Practice") to take photos and/or videos before, during, and after my surgery, procedure, or service. These may be of me or parts of my body (the "Images"). I agree that the Practice can share them with staff, other health professionals, professional certifying board(s), and the public. This may be done for educational, informational, and/or marketing purposes. I understand that in some circumstances the Images may portray features that may make my identity recognizable.

I understand that once the Images are published, I lose control over their use. I have no control over where or how they are used, published, shared, and/or printed. I agree to give up all rights to the Images. I release any claim I may have to the rights to such Images, including any payment for their use, publishing, or distribution.

I understand that Images posted online and on social media may be saved. They may be available forever. They may be found in online searches. I realize that people may print, share, distribute or repost the Images without the Practice's consent. They may be used in social media. Neither I nor the Practice have any control over this. I agree that the Practice is not responsible for third-party use. I release the Practice from any claim that might arise from any third-party use or distribution.

I understand that I have the right to revoke this authorization in writing to the Practice at any time, but if I do so, such revocation will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will exist indefinitely. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from the Practice.

I understand that the information disclosed, or some portion thereof, may be protected by state and/or federal law, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and I hereby waive such protections to the extent I may legally do so. I further understand that there is the potential for information disclosed under the terms of this authorization to be redisclosed by the recipient and no longer protected by HIPAA.

I agree that the Practice can use the Images in the following context **(please initial <u>ONLY ONE</u> of the following):**

_____ALL MEDIA: Photographs taken of me or parts of my body as well as details regarding medical services that I have received may be used in print and broadcast media. This includes newspapers, pamphlets, educational films, the internet (including social media and applications), and television.

_____WEBSITE ONLY: Photographs taken of me or parts of my body as well as details regarding medical services that I have received may be used on the Practice's website.

_____ ALBUM ONLY: Photographs taken of me or parts of my body as well as details regarding medical services that I have received may be used in printed and/or digital photograph albums. The albums will only be used to show other patients the Practice's methods.

I agree to the foregoing specified use of the Images. I have fully read and understand the above terms. I have made my decision carefully and understand the risks.

PATIENT SIGNATURE: _____ Date: _____
Printed Name: _____

WITNESS SIGNATURE: _____ Date: _____
Printed Name: _____

For patients under the age of 18:

I, the parent or guardian of _____, a minor, am authorized to sign this release on his or her behalf. I agree to the educational use of his or her images.

PARENT/GUARDIAN SIGNATURE: _____ Date: _____
Printed Name: _____