PLASTIC SURGERY CONSULTANTS
a Partner of Minnesota Oncology

Patient's Name_____ Date of Birth _____ / _____ / _____
Last First Middle

Photograph Consent and Release

I hereby acknowledge that I have been advised photographs will be taken of me or parts of my body before and after surgery. The photographs will be taken by one of the staff members of the Plastic Surgery Consultants, LTD, a division of Minnesota Oncology Hematology, P.A. (the "Practice"). By signing below, I hereby consent to the taking of such photographs and authorize the Practice to use the photographs under the circumstances indicated below.

Please initial the following:

_____ **Medical Care Only:** Photographs taken of me or parts of my body can be used solely for my medical care with the Practice and its affiliates. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at the Practice.

_____ **Internet:** Photographs taken of me or parts of my body as well as details regarding medical services I have received at the Practice can be used on the Practice's website(s) to inform the public about the Practice's services and plastic surgery methods. I waive the right to inspect or approve the finished product. Further, I release and discharge the Practice and its employees; and all parties acting under their license and authority, from any and all claims or actions I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. My consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I understand photographs, once on the internet, are no longer under the control of the Practice.

_____ **All Media:** Photographs taken of me or parts of my body as well as details regarding medical services I have received at the Practice, can be used in any print or broadcast media, including, but not necessarily limited to newspapers, pamphlets, educational films, internet, social media including but not limited to Facebook and Instagram, and television, as well as the Practice's website(s), in order to inform the public about plastic surgery methods. Further, I release and discharge the Practice and its employees; and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me in connection with any such use or publication. My consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I understand photographs, once on the internet and social media, are no longer under the control of the Practice. I waive the right to inspect or approve the finished product, including printed or electronic copies, wherein my photographs appear. Additionally, I waive any right to royalties or other compensation arising or related to the use of my photograph(s).

I understand that I may choose not to sign this authorization and that such refusal to consent to photographs will in no way affect the medical care I will receive. By signing this form, I acknowledge my consent and authorization as initialed above, and I further recognize that this authorization form will supersede any other photo consent forms with a date prior to the date written below. I can revoke this authorization at any time by sending a written request to the Practice's Privacy Officer at 2550 University Ave W, Suite 100N, St Paul, MN 55102. If I revoke this authorization, my photographs and information will not be used or disclosed as described in this authorization, except to the extent that my authorization has been relied upon (for example, if my photographs are already being used in an ongoing advertising campaign). Upon revocation of this authorization, the Practice will not permit further release of any photography or information but will not be able to call back any photography or information already released. Unless revoked as described above, this authorization shall not expire.

Signature_____ Date_____

Sam Economou M.D. / Valerie Lemaine M.D., M.P.H.

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