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PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I, _____, consent to the taking of photographs or videotapes of me or parts of my body, by Dr. Rottler or his designee, in connection with the following plastic surgery procedure(s) _____to be performed by Dr. Rottler.

I understand that such photographs, videotapes or case histories may be published by Dr. Rottler in any print, visual or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for the purpose of informing the medical profession or the general public about plastic surgery methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that shall make my identity recognizable.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire twenty (20) years from the date written below.

I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Dr. Rottler.

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 further understand that,

I release and discharge Dr. Rottler, and all parties acting under their license and authority from all rights that I may have in the photographs, videotapes or case histories 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 these materials in any medium.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

_____	_____	_____
Patient Name (Print)	***Patient Signature***	***Date***

IF PATIENT IS A MINOR AND UNDER THE AGE OF 18:
I have read the above Authorization and Release. I am the parent, guardian or conservator of _____, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

_____	_____	_____
Patient Name (Print)	***Parent/Guardian Signature***	***Date***

WITNESS/PHYSICIAN SIGNATURE:_____