SAN ANTONIO COSMETIC SURGERY, PA

Patient:_____ Date:_____

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I, _____ , authorize Dr. Delio Ortegon, MD, FACS and/or San Antonio Cosmetic Surgery, PA associates, and/or **his** representative(s), to take photographs, slides or videotapes of me or parts of my body for the following procedure(s) and for medical purposes to be used for my care, medical presentations and/or articles.

In addition, I authorize the use of these images, without compensation to me, for the following specific purposes: (Please **initial** in the boxes marked Yes or No for each item)

Yes	No	Medium
		in the office **photo album** for prospective patients.
		in office **seminars** for prospective patients.
		on our **website** for prospective patients.
		in print **advertisements**.
		on **television**.

Additional Comments:

I understand that:

1. Such photographs, slides or videotapes may be published by Dr. Ortegon and/or San Antonio Cosmetic Surgery, PA associates 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. I understand that such uses may also include marketing on behalf of Dr. Ortegon , for which Dr. Ortegon may be receive direct or indirect remuneration.

2. I will not be identified by name in any of the media described above; however, I also understand that in some circumstances the photographs, slides, or videotapes may display features that identify me.

3. I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to San Antonio Cosmetic Surgery at **9410 Golden Quail, Ste # 140, San Antonio, TX, 78240**. A revocation shall not affect any release of information made prior to revocation in reliance upon this Authorization. If I do not revoke this authorization, it shall expire on the following date, event, or condition: _____ . If I fail to specify an expiration date, event, or condition, this authorization will expire in 1 year, except to the extent action has been taken thereon.

Patient:_____ Date:_____

3. I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Dr. Ortegon and/or San Antonio Cosmetic Surgery, PA associates.

4. The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by applicable federal and/or state confidentiality rules.

5. A copy of this Authorization is valid as the original. I have received a copy of this Authorization. I may inspect or copy information to be used or disclosed under this authorization, as provided by federal and/or state law.

I release and discharge Dr. Delio Ortegon, MD, FACS and/or San Antonio Cosmetic Surgery, PA associates from all liability, including liability for negligence, that in any way arises out of:

any and all rights that I may have or may have had in the photographs, slides or videotapes of me that I have authorized to be used and disclosed in this Authorization; and

any claim that I may have or may have had relating to such use and disclosure of those photographs, slides or videotapes of me, including any claim for payment in connection with any distribution or publication of them in any medium.

This Authorization is made as a voluntary contribution in the interest of public education and certify that I have read this Authorization and Release carefully and fully understand its terms.

If I have questions about the use or disclosure of my photographs, slides, or videotapes, I can contact Practice Director, Cynthia Durieux, RN at (210) 614-4320.

Signature: _____ Date: _____

Witness: _____

If the patient is a minor 17 years of age, and we, the undersigned, are the parents or guardian of the patient and do hereby consent for the patient.

Signature: _____ Date: _____

Witness: _____