



PHOTO CONSENT FORM

Name _____

Address _____
(street address, city, state and zip code)

I consent to the taking of photographs by **Dr. Tenley K. Lawton** or her designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by **Dr. Tenley K. Lawton**. I further authorize **Dr. Tenley K. Lawton** or one of her associates to release such photographs to my chart and insurance companies if needed. If Dr. Lawton should decide to use my photos for educational purposes, she will notify me prior to doing so.

Once I have given my authorization, I understand that such photographs shall become the property of Dr. Lawton and may be retained by Dr. Lawton or released for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals and textbooks, for the purpose of informing the medical profession or the general public about plastic surgery procedures and 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 will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from **Dr. Tenley K. Lawton**.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any affect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire ten years from the date written below.

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, because IPSC is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA.

I release and discharge Dr. Tenley K. Lawton and all parties acting under their license and authority from all rights that I may have in the photographs 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 the photographs.



tenley k lawton m.d.
BOARD CERTIFIED PLASTIC SURGEON

I certify that I have read the above Authorization and Release and fully understand its terms.

PATIENT'S SIGNATURE: _____

RESPONSIBLE PARTY: _____

TIME: _____ DATE: _____

WITNESS: _____

I have read the above Authorization and Release. I am the parent, guardian, or conservator of _____, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization as a voluntary contribution in the interest of public education.

PATIENT'S SIGNATURE: _____

RESPONSIBLE PARTY: _____

TIME: _____ DATE: _____

WITNESS: _____

