**THIS TEMPLATE IS PROVIDED AS A MATTER OF CONVENIENCE – ASPS MAKES NO REPRESENTATIONS REGARDING ITS COMPLIANCE WITH STATE OR FEDERAL LAW. ALL USERS ARE ENCOURAGED TO SEEK ADVICE OF LOCAL COUNSEL REGARDING COMPLIANCE WITH APPLICABLE STATE AND FEDERAL PRIVACY LAW.

HIPAA AUTHORIZATION OF PATIENT IMAGES

 _____Patient Initials

HIPAA AUTHORIZATION OF PATIENT IMAGES

Name _____

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

I permit Dr. Thomas Jeneby or his/her designee to take photos or videos ("Images"). These may be of me or parts of my body. They will relate to the procedure(s) done by Dr. Thomas Jeneby. I also agree to the disclosure of such images and information related to the procedure ("Information").

I agree that my surgeon can keep the images. He/she may share them with other health professionals and members of the public for the following purposes.

Initial ONE of the following.

_____ALL MEDIA My information may be used in any media. This includes newspapers, pamphlets, educational films, the Internet (including social media), and television.

_____WEBSITE ONLY My information may be used on my surgeon's website.

_____ ALBUM ONLY My information may be used in printed/digital photograph albums. These can be used to show other patients my surgeon's methods.

I understand that when this information is published, it is no longer protected by privacy laws. It may be re-published by anyone with access.

I understand that I may refuse to permit disclosure. My refusal will not affect the services I receive.

I understand that I can see and copy the images. I can get a copy of this form. I can revoke my authorization at any time. If I do so, it will not affect anything that happened before my revocation. If I do not revoke this authorization, it will expire 10 years from the date below.

I understand that my information may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). I also understand that upon disclosure the information may no longer be protected. It may be used by any recipients (including the public).

[Signature Page Follows]

I have read and understood the above information. I have made my decision carefully and know the risks.

Signature Date

For patients under the age of 18:

I have read the above information. I am the parent, guardian, or conservator of _____ _____, a minor, and am authorized to sign on his/her behalf.

Signature Date