CONSENT FOR USE OF PHOTOGRAPHS

Medical photographs are routinely obtained in order to help the surgeon plan the meticulous details of each operation. You will be photographed in the office as part of your initial consultation, and then at regular intervals during post-operative visits. These pictures become an integrated part of your medical record and shall be the property of Menard Plastic Surgery, PC.

I HEREBY CONSENT to be photographed by the staff of Menard Plastic Surgery, PC.

_____________________________ _____________________________________ ____________

Print Name Signature of Patient or Legal Guardian Date

_____________________________________ ____________

Signature of Witness Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

_____________________________ _____________________________ ____________

Print Name SS# or Health Record Number Patient DOB

I authorize Menard Plastic Surgery, PC to release/disclose my health information, including my entire medical record, to any and all physicians or entities involved in my medical care.

Please initial each item below to indicate your understanding.

_____ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

_____ I understand once the information is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

______I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

____ Date_______________

Signature of Patient or Legal Guardian

This authorization expires 12 months from the date signed.