

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I hereby authorize Snyderma Dermatology and Plastic Surgery, and/or representative(s) of the practice, to take photographs, slides or videotapes of me or parts of my body for and/or during the following procedure(s) and for medical purposes to be used for my care, medical presentations and/or articles.

I understand that:

1. Such photographs, slides or videotapes may be published by Dr. Snyder and/or Snyderma 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. Snyder, for which Dr. Snyder may receive direct or indirect remuneration.
1. 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.
2. 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 **Kristen Leigh** at 901 W. 38th, Ste 410, Austin, TX 78705. A revocation shall not affect any release of information made prior to revocation in reliance upon this Authorization.
3. I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Dr. Snyder and/or Snyderma.
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 may receive a copy of this Authorization on request. I may inspect or copy information to be used or disclosed under this authorization, as provided by federal and/or state law.
6. **I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.**

I release and discharge Dr. Snyder and/or Snyderma 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 I 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 medical record, I can contact **Kristen Leigh** at **(512)533-9900**.

Signature _____

Date _____

Witness _____