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 ___Patient Initials ©2020 American Society of Plastic Surgeons®
This form is for reference purposes only. It is a general guideline and not a statement of standard of care. Rather, this form should be edited and amended to reflect policy requirements of your practice site(s), CMS and Joint Commission requirements, if applicable, and legal requirements of your individual states. The ASPS does not certify that this form, or any modified version of this form, meets the requirements to obtain informed consent for this particular procedure in the jurisdiction of your practice.

I, _____, permit Dr. Thomas Jeneby ("**my surgeon**") or his/her designee to take photos and/or videos before, during, and after my surgery. These may be of me or parts of my body ("**my images**"). I agree that my surgeon can share them with staff, other health professionals, and the public. This may be done for educational or marketing purposes.

I understand that once my images are published, I lose control over their use. I have no control over where they are published. I agree to give up certain rights to my image. I release any claim I may have to the publication of such images. This includes any payment for their distribution.

I understand that images posted online may be saved. They may be available forever. They may be found in online searches. I realize that people may repost my images without my surgeon's consent. This may be used in social media. Neither I nor my surgeon have any control over this. I agree that my surgeon is not responsible for third-party use. I release my surgeon from any claim that might arise from this use.

I agree that my surgeon can use my images in the following context:

Please initial <u>ONLY ONE</u> of the following

_____ALL MEDIA: My images and medical details may be used in print and broadcast media. This includes newspapers, pamphlets, educational films, the internet (including social media and applications), and television.

_____WEBSITE ONLY: My images and medical details may be used on my surgeon's website.

_____ ALBUM ONLY: My images and medical details may be used in printed and/or digital photograph albums. The albums will only be used to show other patients my surgeon's methods.

(Signature Page Follows)

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I agree to the educational use of my images. I have fully read and understand the above terms. I have made my decision carefully and understand the risks.

PATIENT SIGNATURE: _____ Date: _____

Printed Name: _____

WITNESS SIGNATURE: _____ Date: _____

Printed Name: _____

For patients under the age of 18:

I, the parent or guardian of _____, a minor, am authorized to sign this release on his or her behalf. I agree to the educational use of his or her images.

PARENT/GUARDIAN SIGNATURE: _____ Date: _____

Printed Name: _____

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