c h i c a g o
COSMETIC SURGERY AND DERMATOLOGY

**Patient Name:** «Person_First_Name» «Person_Last_Name»
**ID:** «Person_ID»

20 West Kinzie Street ● Suite 1130 ● Chicago, IL 60654
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## Standard Patient Photographic Consent Form

**Photography for Medical Purposes**

Photographs at CCSD are considered a necessary part of your medical Designated Record Set (DRS). The privacy of images stored in our secure Electronic Heath Records system and used to capture medically relevant data are covered by HIPAA. We may share your medical information to obtain payment for services or to provide treatment or health related services such as coordinating prescriptions, lab work, and other diagnostic tests. We may also disclose your medical information to another covered entity (e.g., a physician's office) for their health care operations in limited circumstances, if that business has a relationship with you. CCSD has the right to refuse any patient who refuses photography for clinical purposes.

I hereby acknowledge that I have been advised that photographs/film/sound recordings will be taken of me, or parts of my body, before and during my care. The photographs will be taken by one of the members of the Chicago Cosmetic Surgery and Dermatology (also referred to as CCSD) staff. I grant CCSD and/or their designee permission use this information for;

x…… *(initials)* Medical purposes related to my case. Photographs taken of me or parts of my body can be used for the purpose of my medical care with CCSD. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at CCSD and remain property of the company.

**Photography for Other Purposes**

A photograph/film or sound recording (also referred to as Materials) that identifies a patient is considered Protected Health Information and cannot be publicly released without authorization.

I hereby consent to the taking of photographs/film/sound recordings of me or parts of my body and grant Chicago Cosmetic Surgery and Dermatology (CCSD) and/or their designee permission to publish, distribute, and otherwise use such Materials for the following purposes;

x…… *(initials)* Scientific purposes, including seminars, medical articles, educational lectures/ presentations/professional conferences such as the ASDS or AAD. I understand that if I am not identifiable from the image, it is not considered to be Protected Health Information and may be used without my permission.

x…… *(initials)* Before-and-after photographs may be used in an album (digital or printed) alongside details regarding medical services that I have received at CCSD in order to inform and help other patients understand treatment methods and result. I understand discretion will be observed wherever possible.

x…… *(initials)* Newsletters, printed materials, publications, electronic communications or other Marketing materials. I understand discretion will be observed wherever possible.

I hereby grant permission for the Materials to be used and edited if necessary without restrictions in any way that CCSD or its designee(s) may consider appropriate to achieve the purposes, in accordance with my consent provided here. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness or altered likeness appears.

I understand that the images may portray features that may identify or otherwise present a recognizable likeness of me.

I understand that the Materials, or some portion thereof, may be 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 re-disclosure, and the information may not be protected by applicable federal and/or state confidentiality rules.

I waive any right to royalties or compensation arising from the use of any Materials and understand that the copyright to all is retained by CCSD who need not approach me again for authorization to use these Materials.

I hold CCSD and their designees harmless from any liability related to the use of these Materials for the purposes outlined above. I release and forever discharge CCSD and their designees from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons acting on my behalf or on behalf of my estate, have or may have by reason of me signing this Standard Patient Photographic Consent Form.

I am at least 18 years of age and am competent to contract in my own name. I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Consent form and fully understand its terms.

…… ……..

x *Signature* x *Date*

……

x *Print Name*

…… ……..

x *Witness Signature* x *Date*

**<u>If the patient signing is under 18 years of age</u>** or under any incapacity, there must be consent by the patient's conservator, guardian or health care representative as follows:

I hereby certify that I am the legal representative of ……, named above, and do hereby give my consent without reservation to the foregoing Patient Photographic Consent From on behalf of this person.

…… ……..

x *Signature* x *Date*

……

x *Print Name*

…… ……..

x *Witness Signature* x *Date*