CLEAR FORM

Please fill out, sign and email to fineryou@fineryou.com or FAX to 888-854-1888

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PATIENT PHOTO/VIDEO CONSENT AUTHORIZATION AND RELEASE

I, _____give my informed and voluntary consent to Jacob Gerzenshtein, M.D. and/or his associates to take photographs and/or video (both using film, disc, digital media) of me or parts of my body during the patient interview, pre-operative, intra-operative, and/or post-operative phases of the procedure. I understand that these photographs and/or videos will be utilized and posted on social media, practice website, and other electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, public or commercial television, electronic digital networks, and Internet web sites, for the purpose of informing medical professionals, students or the general lay public, including current and prospective patients about plastic surgery methods, expectations, and outcomes. All pictures will remain anonymous and any identifying features will be blurred out as best as possible, however, I also understand that in some rare circumstances the photographs and/or videos may display features that identify me.

I understand entirely that this authorization is completely voluntary. I understand that any disclosure of information has the potential of unauthorized disclosure and the information may not be protected by applicable federal and/or state confidentiality rules. Jacob Gerzenshtein or a representative cannot guarantee, nor have liability should you disclose any identifying factors to a third party as they may not be required to maintain your privacy.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my information. By signing this consent, I hereby, knowingly and voluntarily authorize Jacob Gerzenshtein, M.D., to use my photographs) and videos in the manner described above.

I release and discharge Dr. Gerzenshtein, his associates, and all parties acting under their license and authority from all rights that I may have in the photographs, video footage or case histories and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of these materials in any medium. I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

Patient: _____

Witness: _____

OR

I have read the above Authorization and Release. I am the parent, guardian or conservator of _____ _____. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

Person Authorized to Sign for Patient: _____

Witness: _____