DR. CRAIG OSER
PLASTIC SURGERY AND MED SPA
DROSER.COM

AUTHORIZATION FOR RELEASE AND CONSENT OF MEDICAL PHOTOGRAPHS, VIDEOS AND/OR TO PUBLISH

Please read this information carefully and completely concerning granting permission to take and use photographs, videos and/or testimonials. After reviewing, please sign the consent as proposed by Dr. Craig Oser Plastic Surgery and Med Spa.

I hereby authorize Dr. Craig Oser Plastic Surgery and Med Spa and his associates or licensees the right to use my photographs, videos and/or testimonials taken that showcase me and/or the procedure that I am having performed:

☐ **Snapchat**
☐ With eyes showing ☐ Without eyes showing

☐ **Instagram**
☐ With eyes showing ☐ Without eyes showing

☐ **Facebook**
☐ With eyes showing ☐ Without eyes showing

☐ **Twitter**
☐ With eyes showing ☐ Without eyes showing

☐ I hereby grant Dr. Craig Oser Plastic Surgery and Med Spa the right to use my photographs, videos and/or testimonials on their website **(photo gallery, blogs, etc.)**

☐ I hereby grant Dr. Craig Oser Plastic Surgery and Med Spa the right to use my photographs, videos and/or testimonials for professional medical purposes, including but not limited to, showing these images on electronic digital networks for purposes of medical education, patient education, lay publication, advertising and marketing or during lectures to medical or lay groups.

PLEASE PRINT THE FOLLOWING

Patient Name:_____ Date of Birth: _____

Email Address: _____ Telephone: _____

Procedure(s): _____

Physician/Service Provider: _____ Date of Procedure: _____

I hereby certify that I am over 18 years old and that it is my intention to be legally bound by this agreement.

I understand that photographs and/or videos may be taken preoperative, intraoperative and postoperative and at any stage of my procedure and may contain recognizable images of my face and/or body. I understand that all information will be kept confidential and will be reported in an anonymous fashion. I will not be described by name in any publication.

The information, photographs, videos and/or testimonials disclosed under this consent, or some portion thereof, are protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Any use or disclosure of such information, photographs, videos and/or testimonials carries with it the potential for an unauthorized redisclosure. I release Dr. Craig Oser Plastic Surgery and Med Spa, its agents and employees, from all liability in connection with any such redisclosure and/or disclosure and/or use of information, photographs, videos and/or testimonials by individuals and/or entities other than Dr. Craig Oser Plastic Surgery and Med Spa and its agents and employees.

I release Dr. Craig Oser Plastic Surgery and Med Spa, its agents and employees, from all liability in connection with information, photographs, videos and/or testimonials of me authorized pursuant to this release and consent. I waive any right to inspect or approve the information, photographs, videos and/or testimonials prior to use. I release Dr. Craig Oser Plastic Surgery and Med Spa, its agents and employees, from any claim I may have relating to use of the information, photographs, videos and/or testimonials, including any claim for payment in connection with the use of them.

I understand that I may revoke this consent at any time by providing a written request. If I do so revoke this consent, it will have no affect on any use or disclosure of photographs, videos or testimonials prior to the revocation date.

I may refuse to sign this Release and Consent without such refusal affecting the medical treatment I receive with Dr. Craig Oser Plastic Surgery and Med Spa.

Signature: _____ Date: _____

Witness: _____ Date: _____

Thank you for taking the time to complete this information.
Please remember to bring this form with you on the day of your visit.

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