Authorization to Disclose Protected Health Information,
Including Photographs/Films/Videos

I _____ (patient name) understand that pre-, post-, and intra-operative pictures are used for many purposes, including operative planning, education of other physicians and patients, and marketing.

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.

The Board requires that all identifiable characteristics, with the exception of a full face photograph or photograph of a uniquely identifiable characteristic, be blanked out for submission of materials for the Oral Examination of The American Board of Plastic Surgery to protect patient privacy.

I also grant Dr. Nimtz and Commonwealth Plastic Surgery PLLC permission to use my photographs, films, and/or videos (not to reveal names; not to reveal faces except for facial surgery cases) for other purposes as outlined below:

____Education of other physicians
____Education of other patients (in office use)
____Use on Dr. Nimtz and Commonwealth Plastic Surgery PLLC Websites
____Use on other promotional websites—RealSelf.com, loveyourlook.com, etc.
____Use in local/regional advertising

____I authorize this use with the following stipulations: _____
_____

____I DO NOT authorize the use of my photographs/films/video for use on the internet.

_____Patient Signature

_____Witness Signature

_____Date