FORM B

AUTHORIZATION FOR AND RELEASE OF PHOTOGRAPHS

SCULTURA PLASTIC SURGERY

Name _____

Address _____ _____, _____ _____
street address city state zip code

I consent to the taking of photos or video footage by Dr. Jon Bradley Strawn or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Strawn. I further authorize Dr. Strawn or one of his/her associates to release to the American Society of Plastic Surgeons ("ASPS") or the American Board of Plastic Surgery, Inc ("ABPS") such images.

I provide this authorization as a voluntary contribution in the interests of public education. I understand that released photographs shall become the property of ASPS or ABPS and may be retained or released for the limited purpose of including them in any print, visual or electronic media including websites, medical journals and textbooks, for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods. Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the images may portray features that will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Dr. Strawn or Scultura Plastic Surgery.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because ASPS, or ABPS, is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA.

I release and discharge Dr. Strawn, ASPS, ABPS and all parties acting under their license and authority from all rights that I may have in the photographs 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 the photographs.

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.

I certify that I have read the above Authorization and Release and fully understand its terms.

_____ _____
Signature of Patient Date

_____ _____
Signature of Witness Date

_____ _____
Signature of Parent, Guardian, or Conservator Date