Corpus Christi Institute of Cosmetic and Plastic Surgery

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Name: ____

Address: ____
(STREET ADDRESS, CITY, STATE AND ZIP CODE)

I consent to the taking of photograph(s) and/ or by Dr. Vijay Bindingnavele or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Vijay Bindingnavele.

I provide this authorization as a voluntary contribution in the interest of public education. I understand that such photograph(s) and/or video images shall become the property of Dr. Vijay Bindingnavele for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals, textbooks, television, newspaper, magazine article, social media sites (Facebook, Instagram, Snapchat, etc.), and/ or Corpus Christi Institute of Cosmetic and Plastic Surgery publications (newsletters, flyers, brochures, World Wide Web page, etc.); 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. Vijay Bindingnavele.

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 release and discharge Dr. Vijay Bindingnavele and all parties acting under his 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 certify that I have read the above Authorization and Release and fully understand its terms.

Signature: ______________________________ Date: ____________

I have read the above Authorization and Release, I am the parent, guardian, or conservator of

______________________, a minor. I am authorized to sign this authorization on his/her

behalf and I give this authorization as a voluntary contribution in the interest of public education.

Signature: ______________________________ Date: ____________

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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.

____
Patient Signature

____
Witness Signature

____
Date