Patient Photographic Authorization and Release

I, ________________________________,consent to being photographed and/or video recorded Echelon Surgical Specialists, LLC.
Patient Name

I authorize Dr Matthew C Camp and/or Echelon Surgical Specialists, LLC, and/or his/its presentative(s) to take photographs or videotapes (collectively, the "Materials") of me or parts of my body for procedures and for treatment purposes and for use by Echelon Surgical Specialists' internal health care operations, such as to improve quality of care to patients and to educate students and professionals at facilities staffed by Echelon Surgical Specialists.

I agree that the Materials shall be the sole and exclusive property of Echelon Surgical Specialists, free and clear of any claim on my part, and that I shall receive no royalties or other compensation or consideration for the Materials.

I release Echelon Surgical Specialists and its personnel from any and all liabilities which may arise from the use or disclosure of Materials and information under this authorization.

In addition, I authorize the use of these images, without compensation to me, for the following specific purposes:
(Please **initial** in the boxes marked Yes or No for each item)

Yes	No	Medium
		in the office **photo album** (digital and print) for prospective patients
		on our **website** for prospective patients
		in print **materials** (such as brochures)
		on **social media**
		for **educational purposes** (medical conferences and medical publications)

Additional comments: (patient may iterate any restrictions on the above consent such as full-face photographs or other comparable images)

I also authorize Echelon Surgical Specialists to use and disclose information about my medical care and treatment in connection with its use and disclosure of the Materials. The disclosure of the Materials and information is authorized to third parties including but not limited to the general public or medical, scientific or educational audiences via any method or media Echelon Surgical Specialists deems proper, including but not limited to continuing medical education conferences, lectures, presentations, and publications in professional journals, brochures, books, magazines, and the online equivalents. I understand that I may revoke this authorization at any time except to the extent that Echelon Surgical Specialists has already taken action in reliance on it. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to:

Echelon Surgical Specialists – Business Manager
15450 Highway 7
Minnetonka, MN 55345

________**Patient Initials**

I understand that the revocation of this authorization will not apply to the Materials and information that have already been disclosed in accordance with the terms of this authorization. I understand that this authorization will remain in effect unless specifically revoked by me. I understand that Echelon Surgical Specialists will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand that, if Materials and information are disclosed to a third party, the Materials and information may no longer be protected by federal privacy regulations and may be re-disclosed by the person or entity that receives the Materials and information.

I understand that:

1. Such Materials may be published by Dr. Camp and/or Echelon Surgical Specialists, LLC, in any print, visual, or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and internet web sites, for the purpose of informing the medical profession or the general public about plastic surgery methods. I understand that such uses may also include marketing on behalf of Dr Camp and/or Echelon Surgical Specialists, LLC, for which Dr Camp and/or Echelon Surgical Specialists, LLC, may receive direct or indirect remuneration.

2. I will not be identified by name in any of the media described above; however, I also understand that in some circumstances the Materials may display features that identify me.

3. I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to the Business Manager at 15450 Highway 7 Minnetonka, MN 55345 or by emailing info@echelonspecialists.com. A revocation shall not affect any release of information made prior to revocation in reliance upon this Authorization.

4. I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Dr Camp and/or Echelon Surgical Specialists, LLC.

5. The information disclosed under the Authorization, or some portion thereof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by applicable federal and/or state confidentiality rules.

6. A copy of this Authorization is valid as the original. I have received a copy of this authorization. I may inspect of copy information to be used or disclosed under this authorization, as provided by federal and/or state law.

I release and discharge Dr Camp and/or Echelon Surgical Specialists, LLC, from all liability, including liability for negligence, that in any way arises out of:

> any and all rights that I may have or may have had in the Materials or me that I have authorized to be used and disclosed in this Authorization; and
>
> any claim that I may have or may have had relating to such use and disclosure of these Materials or me, including any claim for payment in connection with any distribution or publication of them in any medium.

This Authorization is made as a voluntary contribution in the interest of public education and certify that I have read this Authorization and Release carefully and fully understand its terms.

If I have questions about the use of disclosure of the Materials of me, I can contact the business office at 612-424-2767 or email info@echelonspecialists.com

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Patient Signature **Date**