

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

Dr. Blanchet believes that medical photographs are a necessary aspect of your treatment and medical records. Photographs are used for planning your surgery, comparing “before” and “after” results, insurance company reviews for extent of injury, determination of benefits, and medical/legal matters.

In connection with the medical services which I am receiving from Dr. Nadia Blanchet, I consent that clinical photographs may be taken of me or parts of my body, under the following conditions:

- Dr. Nadia Blanchet or her designee shall take the photographs.
- The photographs shall be used for the purpose of medical records and shall remain the property of Dr. Blanchet.
- The photographs shall be used for medical records. If in the judgment of Dr. Blanchet, medical research, education or science will benefit by their use, such photographs and information relating to my case may be published and republished, either separately or in medical books, or used for any other purpose which she may deem proper in the interest of medical education, knowledge, or research, provided, however, that is specifically understood that in any such publications or use I shall not be identified by name.
- I understand that my photographs may be used on Dr. Blanchet’s web site and that my name will not be printed.
- Our **Notice of Privacy Practices** provides information about how we may use and disclose PHI about you. You have the right to review our **Notice of Privacy Practices** before signing this consent.

I understand that such photographs may be used and disclosed in any print for treatment, payment and health care operations. I understand that I have the right to revoke this consent, in writing, but if I do so it won’t have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire ten years from the date written below.

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

Print Name: _____ Date: _____
 Patient’s signature _____ Date: _____

I have read the above Authorization and Release. I am parent, guardian or conservator of _____, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent.

Print Name _____ Date _____
 Parent/Guardian Signature _____ Date _____
 WITNESS: _____ Date _____

4/30/14