**Kamran Abolmaali, MD**
North Atlanta Plastic Surgery Group LLC (NAPSG) / Aesthetic International USA LLC

**Patient Name:** **Date of birth: / /**

# PATIENT INFORMATION AND PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I, _____ , authorize Dr. Abolmaali and/or his affiliations, and/or his representative(s), to take photographs, slides or videotapes of me or parts of my body for medical and esthetic purposes to be used for my care, medical presentations and/or articles.

In addition, I authorize the use of these images and my patient information, 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 for educational purposes/prospective patients |
| | | in office seminars for prospective patients |
| | | on our website for prospective patients |
| | | on all websites associated with plastic surgery services (e.g. ASPS, Locate A Doc, Love Your Look, Real Self) |
| | | in print press releases, articles and/or advertisements. |
| | | social Media (e.g. Instagram, facebook) |
| | | use of satisfaction survey comments in brag book and/or websites |

I understand that:

1. Such patient information, photographs, slides or videotapes may be published by Dr. Abolmaali and/or his affiliations or their Public Relations contacts in any print, visual, or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet websites, for purpose of informing the medical profession or the general public about plastic surgery methods and esthetic services. I understand that such uses may include marketing on behalf of Dr. Abolmaali, and NAPSG, for which Dr. Abolmaali, and NAPSG staff may receive direct or indirect remuneration.
2. I will be identified by name in any publication, unless specified. I understand that in some circumstances the photographs may portray features that will make my identity recognizable. Initial here if you do not want your name used _____ .
3. I understand the nature of the release and consent to Dr. Abolmaali, and NAPSG staff discussing my case with the press.
4. 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.
5. I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I have the right to revoke the authorization in writing at any time and, if I decide to do so, I must present my written revocation to Dr. Abolmaali's office. A revocation shall not affect any release of information made prior to revocation in reliance upon this Authorization.
6. The information disclosed under this authorization, or some portion thereof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ('HIPPA'). 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.
7. A copy of this authorization is valid as the original. I have received a copy of this Authorization. I may inspect or copy information to be used or disclosed under this authorization, as provided by federal and/or state law.

I release and discharge Dr. Abolmaali and/or his affiliations 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 photographs, slides or videotapes of 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 those photographs, slides or videotapes of 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 released to the ASPS, I understand that such photographs shall become property of ASPS and may be retained by ASPS or released by ASPS for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals and textbooks, for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

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

Signature _____ Date _____

Witness _____ Date _____