The Larrabee Center for Facial Plastic Surgery
600 Broadway
Seattle, WA 98122
Phone: 206.386.3550
Fax: 206.386.3553
Email: info@larrabeecenter.com

Photo Use Authorization Form

I have consented to the taking of photography, audio/visual recordings or other images of me by the Larrabee Center for Facial Plastic Surgery, which will become part of my medical record. I understand that my photographs, videotapes, digital, and other images may be recorded to document and assist with my care. I acknowledge that the Practice will own these images, but that I will be allowed access to view them or to obtain copies of them as part of my medical record. I also understand that the images that identify me can be released and/or used outside the Practice only upon written authorization from me.

_____ _____
Patient Signature (Or Personal Representative) Date

_____
Printed Name

In addition, I authorize Practice to use my photographs, videotapes, digital, and other images for educational, commercial and other purposes as follows (*please select the items below you authorize)*:

- ☐ MEDICAL
- ☐ INTERNET
- ☐ IN OFFICE

PHOTO LIMITATIONS:

_____

_____ _____
Patient Signature (Or Personal Representative) Date

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I understand that:

- This authorization is voluntary. My treatment will not be impacted, no matter if I sign this authorization or not.
- This authorization will end only when the use and disclosure of my information is no longer needed for the purposes agreed to above. I may revoke this authorization by mailing or faxing my written request to the Larrabee Center for Facial Plastic Surgery.
- This withdrawal would affect only future use and disclosure of my information, photographs, and images, which have not been previously published or disclosed. I understand that this withdrawal would NOT affect any non- Larrabee Center TV, radio, newspaper, and other commercial media once they have received my information or recorded my image.
- Once my health information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.

_____ _____
Patient/Personal Representative Initials Date