



Benjamin J. Boudreaux, M.D.

Informed Consent for Photographic Release

Patient Name _____

Address _____
(street address, city, state and zip code)

I consent to the taking of photographs by Dr. Benjamin Boudreaux or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Boudreaux. I further authorize Dr. Benjamin Boudreaux or one of his/her associates to release to the American Society of Plastic Surgeons® (“ASPS®”) such photographs.

I provide this authorization as a voluntary contribution in the interests of public education. I understand that such photographs shall become the property of Dr. Benjamin Boudreaux and may be retained by Dr. Boudreaux or released by Dr. Boudreaux for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals, textbooks, brochures or web sites 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 photographs 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. Benjamin Boudreaux.

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. If I do not revoke this authorization, it will expire ten years from the date written below.

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 further understand that, because Dr. Benjamin Boudreaux is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA.

I release and discharge Dr. Benjamin Boudreaux, ASPS, and all parties acting under their 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 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.

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

Patient Print Name Date

Witness Print Name Date

Patient Signature

Witness Signature