**PHOTOGRAPH AND VIDEO CONSENT AND RELEASE FORM (“Consent”)**

**Purpose of Release**: The purpose of this Release is to give your permission to Facility name here, to use your information for Facility name here own advertising, publicity, educational, and promotional purposes. In addition, you hereby are providing your permission for disclosure of your information, as set forth below, to the American Society of Breast Surgeons (“ASBS”).

ASBS is one of the pre-eminent professional societies for breast surgeons, and among its tasks is the provision of medical education for its members. As such, the ASBS endeavors to create a video library to demonstrate operative techniques and set a community standard for operative procedures.

Your Facility name here doctor (“surgeon”) has identified you/your surgical case as appropriate for teaching purposes and demonstration of techniques. Your consent for photography and videography (“images”) pertaining to your breast surgical care is requested.

Without your consent, no images will be used for these purposes. Consent will be considered durable and may not be canceled in the future as all images will be de-identified and may not be retrievable. These images will not be entered into your medical record and will be turned over to the ASBS promptly after surgery. The final published product will be de-identified which may include removing identifying marks such as scars, birthmarks, tattoos, or other marking. As such, the ASBS will not know your identity and cannot return images nor retrieve copies for you. Your Facility name here surgeon will not retain records or copies of your images unless they are incorporated into your medical record. You are not required to provide consent, and refusing to provide consent will have no impact upon your medical treatment. This is voluntary, and it provides no direct benefit to you less the knowledge that you are helping advance medical education which may benefit others. I understand I will receive no compensation for my images. Anticipated harm is minimal but principally includes risk of accidental disclosure of your identity and potential for prolongation of your operative case. Additional specific anticipated benefits or harms to you beyond those listed here should be discussed in detail with you by your Facility name here surgeon. If you have any questions talk to your Facility name here surgeon and ensure all of your questions are answered prior to signing this form. By signing this consent you acknowledge that you understand and agree as follows:

* I hereby authorize Facility name here surgeon, ASBS and its designated representatives to take and use preoperative, intraoperative and postoperative videos and/or photographs create an online educational video available to its membership relating to the surgical procedure to be performed on Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Promptly after surgery, Facility name here surgeon will supply these images and/or videos to ASBS which will use them for educational purposes, including in person and online access by physicians and medical students.
* As a condition of this consent identifying marks such as scars, birthmarks, tattoos, or other marking. However, this is no guarantee that I will not be identified as part of the use.
* ASBS will not receive or retain information regarding my identity such as my name, address, phone number.
* Although I may revoke my consent in writing, such will not affect or limit ASBS’s past or continued use of the images, as ASBS will not retain information sufficient to identify images and/or videos regarding your surgery.
* These images and videos may be subject to redisclosure by those who have access the use
* I am not required to provide consent, and refusing to provide consent will have no impact upon my medical treatment.
* Anticipated harm is minimal but principally includes risk of accidental or otherwise unauthorized disclosure of your identity and potential for prolongation of your operative case. Additional specific anticipated benefits or harms to you beyond those listed here should be discussed in detail with you by your Facility name here surgeon. If you have any questions, talk to your Facility name here surgeon and ensure all of your questions are answered prior to signing this form.
* I understand that such photography and videography shall remain property of the surgeon and ASBS.

Based on the foregoing, I fully and specifically grant my permission to the surgeon and ASBS to record photographic and video images of my surgery and for Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to release the images and video to ASBS for its educational Use as described above.

My initials below authorize:

\_\_\_\_\_ Facility name here surgeon, ASBS and its designated representatives to take and use preoperative, intraoperative and postoperative videos and/or photographs create an online educational video available to its membership

\_\_\_\_\_ Facility name here surgeon, ASBS and its designated representatives to share images/educational videos live at professional medical meetings or courses

\_\_\_\_\_ Facility name here surgeon, ASBS and its designated representatives to share images/educational videos with other professional societies and individual medical professionals for educational purposes only

\_\_\_\_\_ Facility name here surgeon, ASBS and its designated representatives to use video and images to create patient education material

\_\_\_\_\_ Facility name here surgeon, ASBS and its designated representatives to use video and images for other educational lectures, live, in print, online or other electronic media

As a result of these uses listed above, I understand that these images and/or case information pertinent to education may appear in other related, updated or reprinted formats at any concurrent or future occasion. I understand that my images, if used for the purposes authorized above, may be subject to redisclosure and may not be subject to any privacy protection. I affirm that this release was not obtained through payment, duress or undue influence. This authorization shall expire when the photographs, video or care information are no longer needed by my Facility name here surgeon and ASBS.

**I hereby release, waive and forever discharge any and all claims, causes of action, damages, liability and obligations that may have or later assert against the surgeon, ASBS and/or their authorized designees in connection with or related in any way to the authorized above uses or disclosures of any photographs, videos or case information including without limitation, for defamation, invasion of right to privacy, publicity or personality or any similar matter, or based upon or relating to the use and exploitation of the photographs or video.**

This Release is governed by and interpreted in accordance with the laws of the State of \_\_\_\_\_\_\_\_\_\_, without regard to its choice of law provisions.

I have read this Release, understand it, and am signing it voluntarily. By my signature, I represent that I am at least eighteen (18) years of age, or if the Patient is a minor - that I am the legal representative of the Patient, and am free to execute this Release.

**THE PATIENT OR PATIENT’S REPRESENTATIVE, IF APPLICABLE, MUST SIGN THIS FORM:**

|  |  |
| --- | --- |
| Signature | |
| Name (please print) | Date |

**TO BE COMPLETED IF THE INDIVIDUAL IS A MINOR**: I confirm that I am the parent or legal guardian of the person identified below, who is a minor and who has entered into the Release with United, and that I have read and approve of the content of this Release and I consent to its execution by my child/ward.

I hereby agree to release United in accordance with the terms of this Release.

|  |  |
| --- | --- |
| Minor’s Name (please print) | |
| Parent/Guardian’s Name (please print) | |
| Parent/Guardian’s Signature | Date |

**HEALTH INFORMATION RELEASE (HIPAA RELEASE)**

*This Health Information Release is for use with individuals that are undergoing surgery at* Facility name here

This HIPAA Release must be signed if my surgery will be photographed or recorded. This HIPAA Release concerns protected health information (“PHI”) under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), which I agree to share with Facility name here in accordance with the terms of this Release.

**Release of My Protected Health Information:** I agree to share PHI with Facility name here. I agree that Facility name here can use and release that PHI on this basis:

* Facility name here surgeon may release the Images and video to American Society of Breast Surgeons (“ASBS”).
* Although Surgeon and ASBS has agreed to take steps to limit distinguishing characteristics of the Images that may identify me, these images might constitute PHI.
* My authorization is voluntary and I may choose not to sign this form. If I choose not to sign this form, I will not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits.
* I further authorize Facility name here surgeon to record and/or photograph my surgery and use and disclose all PHI that is included in the images or videos for educational purposes.
* I understand that the PHI that I share, as part of my surgery video and images, these will be shared with third parties by Facility name here and that those third parties could further share that PHI, so that it would no longer be protected by HIPAA.
* I may tell Facility name here at any time by sending a written request to Facility name here,

Add mailing address here\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I understand that my decision to revoke my permission will not have any effect on PHI which was released or used by Facility name here surgeon or by someone authorized by Facility name here surgeon before it received my written revocation.

This release will continue in effect until I either revoke my permission or it otherwise expires automatically under state law.

I hereby authorize Facility name here to use and disclose any PHI in my images and/or videos. I have read the Release & Consent and this HIPAA Release, understand both, and am signing both voluntarily:

|  |  |
| --- | --- |
| Signature | |
| Name (please print) | Date |

**TO BE COMPLETED IF THE INDIVIDUAL IS A MINOR OR HAS PERSONAL REPRESENTATIVES**: I confirm that I am the parent legal guardian (if the person identified below is a minor) or other personal representative (“Representative”) of the Subject identified below, who is the subject of this authorization, and that I have read and approve of the content of this and I consent to its execution by my child/ward.

I hereby agree to release Facility name here in accordance with the terms of this HIPAA Release.

|  |  |
| --- | --- |
| Minor’s Name (please print) | |
| Parent/Guardian’s Name (please print) | |
| Parent/Guardian’s Signature | Date |