

Patient Photographic Consent Form

As part of my care and services provided by *Michael DeWolfe, M.D.*, I hereby grant permission to the taking of photographs by *Michael DeWolfe, M.D.* or his designee of me and parts of my body relating to the plastic surgery procedures indicated.

I understand that such photographs become part of the medical record with MacNeal Physicians Group, and that all identifiable information related to such photographs will be stored in a password-locked database that is only accessible to *Michael DeWolfe, M.D.*, his associates, or designees. I understand that the information disclosed, or some portion thereof, may be protected by the state law and/or the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that all identifiable, or protected health information (PHI) will be kept in the strictest confidentiality in accordance with HIPAA by my physicians.

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. It is my understanding that all identifiable characteristics, with the exception of a full face photograph or photograph of a uniquely identifiable characteristic, be blanked out of submission of materials for the Oral Examination of The American Board of Plastic Surgery to protect patient privacy.

As *Michael DeWolfe, M.D.*, and his associate or designee, I understand that such photographs may be published 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 methods. I understand that photographs, health or personal information will not be used for any advertising or commercial purposes.

I understand my right to revoke or refuse such authorization for the taking of photographs and/or release of such photographs or no identifiable medical information to The American Board of Plastic Surgery, Inc. Such revocation or refusal will not impact my care or services provided by *Michael DeWolfe, M.D.*, his associates or designees.

Patient Name: _____

Patient Signature: _____

Witness Signature: _____

Date: _____