

MARCIA V. ORMSBY, M.D.
ANNAPOLIS AESTHETIC SURGERY

An Artist's Eye. A Woman's Touch

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

Patient Name: _____

Date of Birth: ____/____/____

I, the undersigned consent and authorize Dr. Marcia Ormsby to obtain pre-operative, operative, and post-operative photographs of me or parts of my body as deemed necessary for the complete documentation and illustration of my surgical treatment.

I understand that such photographs may appear in medical publications or conferences, presentations and teaching courses and internet web sites, for the purpose of informing the medical profession or the general public about plastic surgery 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 shall make my identity recognizable.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire twenty (20) years from the date written below.

I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Dr. Marcia Ormsby.

_____ You may publish my photos using the guidelines as stated above.

_____ Chart Only; I do not wish to have my photos published.

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 1998 ("HIPAA").

I release and discharge Dr. Marcia Ormsby from all rights that I may have in the photographs, 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 these materials in any medium.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

Signature _____ Date _____

Witness/Physician: _____

I have read the above Authorization and Release. I am the parent, guardian or conservator of _____, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

Parent or Guardian _____ Date _____

04/11