



ALLISON LIED PLASTIC SURGERY

I, _____, authorize Dr. Allison Lied/Allison Lied Plastic Surgery, L.L.C. and/or her representative(s), to take photographs of me or parts of my body for medical purposes to be used for my care or medical presentation.

In addition, I authorize the use of these photos, without the compensation to me, for the following specific purposes:

Yes No

_____ In the office PHOTO ALBUM/COMPUTER for prospective patients
_____ In SEMINARS conducted by Dr. Lied/staff for prospective patients

Patient

Comments: _____

I understand that:

1. I will not be identified by name in any of the media described above however, I also understand that in some circumstances the photographs may display features that identify me.
2. I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Dr. Lied/Allison Lied Plastic Surgery, L.L.C./Cincinnati Onco-Plastic Surgery.
3. I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to 4460 Red Bank Rd., St 120. A revocation shall not affect any release of information made prior to revocation in reliance upon this authorization, it shall expire on the following date, event or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will not expire except to the extent action has been taken thereon.
4. The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by applicable federal and/or state confidentiality rules.
5. A copy of the Authorization is valid as the original and available to me at my request. I may inspect or copy information to be used or disclosed under this authorization, as provided by federal and/or state law.

I release Dr. Lied/Allison Lied Plastic Surgery, L.L.C./Cincinnati-Onco Plastic Surgery/ from all liability, including liability for negligence that in any way arises out of:

Any and all rights that I may have or may have had in the photographs of me that I have authorized to be used and disclosed in the Authorization and any claim that I may have or may have had relating to such use and disclosure of those photographs including any payment in connection with any distribution or publication of them in any medium.

This Authorization is made as a voluntary contribution in the interest of public education and certify that I have read the Authorization and Release carefully and fully understand its terms.

If I have questions about the use or disclosure of my photographs I can contact the office at (513) 272-1999.

Signature/Guardian: _____ Date: _____
Witness: _____