



RYAN CONSTANTINE, MD
PLASTIC, RECONSTRUCTIVE & HAND SURGERY

Patient Photographic Authorization & Release

Ryan Constantine, M.D.

I hereby authorize Ryan Constantine, MD, and his employees or agents, to photograph me or parts of my body, and/or make electronic recordings of me (hereafter referred to as photographs) in connection with the plastic surgery procedure(s) he has performed, or may perform.

I authorize the use of any such photographs of me for purposes of my treatment, educational endeavors, and quality assurance review. I further authorize Ryan Constantine, MD, or his associates to release to the American Society of Plastic Surgeons (ASPS) and/or to the American Society for Surgery of the Hand ("ASSH") such 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. (ABPS).

I understand that Dr. Constantine may publish such photographs 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.

The Board requires that all identifiable characteristics, with the exception of a full face photograph or photograph of a uniquely identifiable characteristic, be blanked out for submission of materials for the Oral Examination of The American Board of Plastic Surgery to protect patient privacy. 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, and that if I do so, it will not have any effect on any actions taken prior to my revocation. 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. Constantine.

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 the ASPS/ABPS is not receiving the information in the capacity of a healthcare provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA and may be disclosed by ASPS/ABPS.

I release and discharge Dr. Constantine, ASPS/ABPS, 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 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.

Patient: _____ **Date:** _____

Witness: _____

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 or her behalf and I grant this consent as a voluntary contribution in the interest of public education.

Parent/Guardian: _____