



**PATIENT PHOTO RELEASE FORM**

NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_

I consent to the taking of photographs by Dr. Lohner or his designee of the parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Lohner.

I provide this authorization as a voluntary contribution in the interests of Public Education. I understand that such photographs can be used in any print, visual or electronic media, specifically including, but not limited to, medical journals and textbooks, advertisements for the purpose of informing the medical profession or the general public about plastic surgery procedures and 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 will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive from Dr. Lohner.

I understand that I have the right to inspect and copy the information I have authorized. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so, it will not have any effect on actions taken prior to my revocation. If I do not revoke this authorization, it will expire ten years from the date written below.

I release and discharge Dr. Lohner and all parties acting under their license and authority from all rights that I may have in 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.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I have read the above Authorization and Release. I am the parent, guardian, or conservator of \_\_\_\_\_, a minor. I am authorized to sign this authorization on his/her behalf, and I give this authorization as a voluntary contribution in the interest of Public Education.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date