Plastic & Reconstructive Surgery, PC

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CONSENT FOR PHOTOGRAPHY

Patient Name ______________________________ **DOB:** ______________________

Due to the nature of our specialty, insurance companies often require photographs to support the medical necessity of a procedure. It's also advantageous to have "before and after" photographs to help document your progress. In some cases, we cannot do a procedure without photographs. Therefore, we request this consent for photography.

I hereby consent to the photographing and recording of myself for the purposes of information and documentation by Plastic and Reconstructive Surgery, PC.

I understand that my photographs may be released to my insurance company if they are required for precertification of a procedure or to support billing for charges for services performed on my behalf.

I also understand that in all other circumstances, my photographs will not be released by Plastic and Reconstructive Surgery, PC, without my express written consent to do so.

Signed ____ Date ______________________
(PATIENT OR PERSON ACTING IN BEHALF OF PATIENT*)

***IF THE PATIENT IS UNDER THE AGE OF 18, THIS FORM MUST BE SIGNED BY A PARENT, LEGAL GUARDIAN OR AN ADULT WITH POWER OF ATTORNEY FOR THE PATIENT'S MEDICAL CARE.**

*If signature is that of someone holding POWER OF ATTORNEY, or LEGAL GUARDIANSHIP giving authority for patient's medical care, we must have a copy of the legal document in the patient's chart.

If signature is not that of patient, state relationship of signer to the patient: ______________________

NOTE: Your health information will be kept confidential. If a claim is submitted to your insurance carrier, it may contain this information; however, your insurance carrier is also required to keep your medical information confidential

Reviewed & Revised 02/08