PHOTOGRAPHY AUTHORIZATION, RELEASE & AGREEMENT FORM

I, _____ irrevocably give Arkansas Plastic Surgery (APS), its duly
(PATIENT NAME PRINTED)
authorized employees, subsidiaries, assigns, successors, licensees or agents, to publish, use, copyright, and distribute all photographs, slides, videos, and case information from the time of initial consultation going forward unless otherwise stated below the ability to use images, likeness, case information (e.g., information relating to the diagnosis, treatment, and health care services provided or to be provided to me and which may directly or indirectly lead to identification) to be used in print media, on the radio, TV, the APS website, blog, journal articles, books, Payson/physician education material, multimedia presentations for an audience of medical professionals or general public, art, promotion, advertising, lectures, editorial and on the following social media platforms including but not limited to: Facebook, Instagram, TikTok, YouTube, and Pinterest.

Please indicate below the following areas where you consent to the use of your pictures. (Initial all that apply)

_____ APS Website
_____ APS/ Dr. Zachary Young Social Media Accounts

_____ Full face can be shown with no exceptions **OR**
_____ Face can be shown with personal identifiers concealed (ie eyes, tattoos, scars, etc..)

_____ Body can be shown without concern for personal identifiers (ie tattoos, scars, etc..) **OR**
_____ Body can be shown with personal identifiers concealed (ie tattoos, scars, etc..)

OR
_____ I consent to the use of my photos with no exceptions
_____ I do not consent to the use of my photos

I further release, discharge, and save harmless Arkansas Plastic Surgery, its doctors, employees, subsidiaries, successors, assigns, and licensee's from all claims and liabilities whatsoever in law and in equity arising from such use. I understand that any personal health information or other information released via the social media platform(s) above may be subject to re-disclosure by such social media platform(s) and may no longer be protected by applicable Federal and State privacy laws. This authorization is valid from the date of my/my representative's signature below and shall expire on _____, **OR** continue indefinitely if not otherwise stated.

I understand that I have a right to revoke this authorization by providing written notice to APS. However, this authorization may not be revoked if APS, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I state that I have read the above authorization, release, and agreement prior to its execution, and that I am fully familiar with the contents thereof.

I am 18 years of age or over or have had this form signed by my parent or guardian.

Name of Person being photographed (PRINTED): _____ Date of Birth: _____

Signature of Patient/Guardian: _____ Date: _____

Witness Signature: _____ Date: _____