SCULTURA
PLASTIC SURGERY

Jon Bradley Strawn, M.D., M.B.A

PATIENT PHOTOS

Patient images are used for many purposes in medical practice. They are placed in the medical record as an adjunct to clinical care, displayed to colleagues, students and other audiences in educational settings, and published in medical journals or other media as part of medical research. In each case it is not only prudent, but necessary for the patients' protection and interest that appropriate consent be obtained.

Clinical photography of patients may be appropriate for the diagnosis and treatment of medical conditions as well as professional education. Clinical photography can be accomplished through a variety of multimedia technology to collect, analyze, and store patient protected health information. Use of these medias will be carefully controlled and executed in compliance with all state and federal regulations as well as other organizational policies and procedures.

Clinical photographs are considered a part of the legal health record. Images will be maintained in accordance with all organizational record retention policies and procedures. Images that are sensitive in nature may be stored in a further safeguarded manner.

USE OF PHOTOS

I ______________________________________ consent for medical photographs and/or videos to be taken of me by Jon Bradley Strawn, M.D., M.B.A or a Team Member of Scultura Plastic Surgery. I understand the information may be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journals.

By consenting to these medical photographs and/or videos, I understand I will not receive payment from any party. Although these photographs will be used without identifying information such as my name, I understand it is possible someone may recognize me. Refusal to consent to photographs will in no way affect the medical care I will receive. If I wish to withdraw my consent in the future, I may do so with a written request.

I understand I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so I won't have any effect on any actions taken prior to my revocation.

I authorize the use of these images: (Please initial indicating YES or NO below):

YES NO Office photo album

YES NO On our website for prospective patients

YES NO In print advertisements and/or professional journals

YES NO Social Media Platforms

YES NO Private in office use for prospective patients

I certify that I have read the above authorization and release, and fully understand it's terms.

Patient Signature ____ Today's Date ___________________