



Lincoln Aesthetic Surgical Institute

BRYANLGH PHYSICIAN NETWORK

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Phone (402) 483-8530 Fax (402) 483-8531

Authorization for and release of medical photographs/slides and/or video footage

Authorization for release of patient images

Name: _____

Address: _____

(STREET ADDRESS, CITY, STATE AND ZIP CODE)

I authorize Dr. Cassidy D. Mitchell, M. D. and BryanLGH Physician Network, Inc., d/b/a Lincoln Aesthetic Surgical Institute, and its staff, employees and agents to use, release and/or disclose my images, including photographs, still or motion pictures or video or other media formats, for the purposes of medical education/research and advertising/promotion. I understand that the use, release and/or disclosure of my images includes use in professional journals and/or medical books, medical education seminars or meetings or for the purpose of certification or re-certification by professional organizations, including but not limited to, the American Board of Plastic Surgery, Inc. and the American Society of Plastic Surgeons. In addition, I release my images for use, release and/or disclosure in media, including but not limited to, websites, advertising, newspapers, journals, magazines, newsletters, brochures, booklets, broadcast news/feature stories, displays and publicity/promotion.

I understand that the information used, released and/or disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPPA") and that I have the right to refuse to agree to this authorization. Neither I nor any member of my family will be identified by name in any publication without specific additional written approval. I understand that in some circumstances, the images, including full face photographs as well as images of other body parts, may portray features such as tattoos or other characteristics that will make my identity recognizable. I understand that specific demographics, such as my age and sex and procedure performed, may be included with my images.

I understand that by signing this authorization, I am waiving all rights that I or my successors, heirs, assigns, or estate may have for any claims for payment of any kind, including but not limited to, royalties, in connection with any exhibition, publication, televising or any other use, release and/or disclosure, regardless of whether such exhibition, publication, televising, or other use, release and/or disclosure was under philanthropic, commercial, institutional or private sponsorship and irrespective of whether a fee of admission is charged.

I understand that I have the right to inspect and copy the information that I have authorized to be used, release and/or disclosed. I further understand that I have the right to revoke this authorization at any time by submitting a written revocation to Cassidy D. Mitchell, M.D., but if I do so, it won't have any effect on any actions taken prior to my revocation. I also understand that once publications that include my images have been distributed, those publications cannot be withdrawn from circulation. I further understand that once the images are released pursuant to this authorization, the information might be re-disclosed and no longer protected by privacy laws, including HIPAA. If I do not revoke this authorization, it will expire two years from the date written below.

I do specifically agree, discharge and hold harmless Dr. Cassidy D. Mitchell, M.D. and BryanLGH Physician Network, Inc., d/b/a Lincoln Aesthetic Surgical Institute, and its staff, employees and agents from any and all liability arising in any way connected with the publication or any use, release and/or disclosure of my images pursuant to this authorization.

I understand that my agreement or refusal to authorize the use, release and/or disclosure of my images will not affect any health care services or treatment I presently receive or will receive in the future from Dr. Cassidy D. Mitchell or BryanLGH Physician Network, Inc., d/b/a Lincoln Aesthetic Surgical Institute, and its staff and employees.

I certify that I have read the above Authorization and fully understand and **agree** to its terms.

Signature: _____

Date/Time: _____

I have read the above Authorization and fully understand and **agree** to its terms; 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.

Signature: _____

Date/Time: _____

I have read the above Authorization and **deny** the use, release and/or disclosure of my images under its terms.

Signature: _____

Date/Time: _____

Witness to Signature Only: _____