# HIPAA AUTHORIZATION OF PATIENT IMAGES

MAGANA
plastic surgery

 _____Patient Initials 

**HIPAA AUTHORIZATION OF PATIENT IMAGES**

Name _____
_____

Address _____
_____
(street address, city, state, and zip code)

I permit Dr. Rafael Magana or his/her designee to take photos or videos ("Images"). These may be of me or parts of my body. They will relate to the procedure(s) done by Dr. Rafael Magana. I also agree to the disclosure of such images and information related to the procedure ("Information").

I agree that my surgeon can keep the images. He/she may share them with other health professionals and members of the public for the following purposes.

**Initial ONE of the following**.

_____ALL MEDIA My information may be used in any media. This includes newspapers, pamphlets, educational films, the Internet (including social media), and television.

_____WEBSITE ONLY My information may be used on my surgeon's website.

_____ ALBUM ONLY My information may be used in printed/digital photograph albums. These can be used to show other patients my surgeon's methods.

I understand that when this information is published, it is no longer protected by privacy laws. It may be re-published by anyone with access.

I understand that I may refuse to permit disclosure. My refusal will not affect the services I receive.

I understand that I can see and copy the images. I can get a copy of this form. I can revoke my authorization at any time. If I do so, it will not affect anything that happened before my revocation. If I do not revoke this authorization, it will expire 10 years from the date below.

I understand that my information may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). I also understand that upon disclosure the information may no longer be protected. It may be used by any recipients (including the public).

[Signature Page Follows]

I have read and understood the above information. I have made my decision carefully and know the risks.

_____ _____

Signature Date

**For patients under the age of 18:**

I have read the above information. I am the parent, guardian, or conservator of _____ _____, a minor, and am authorized to sign on his/her behalf.

_____ _____

_____

Signature Date

 _____Patient Initials 