Patient Name _____

AUTHORIZATION FOR RELEASE OF PATIENT PHOTOGRAPH and VIDEO

I agree to take photographs of myself or parts of my body in relation to the plastic surgery procedure (s) that have been or may be performed. Dr. Reilly and his staff are authorized to take these photographs and use them during conferences, on their own website, plastic surgery directory websites in which Dr. Reilly has a presence (i.e. Realself.com, American Society of Plastic Surgeons) and / or to distribute them in printed form and / or electronic means to inform potential patients. Neither I nor any member of my family will be identified by name in any publication. If facial photographs are included, it is likely that my identity will be recognizable. My jewelry, tattoos, distinctive clothing, and / or other characteristics may also reveal my identity.

If I agree to participate in a brief interview to be videotaped after my procedure, in order to explain my experience of plastic surgery to others who are considering undergoing this procedure, this video can be posted on plastic surgery websites without my name or other identifying information, unless I say my name myself. It is strictly forbidden to record any videos during my surgical procedure

I have given this authorization voluntarily, and will be in effect until you send a written request to Dr. Reilly to withdraw this authorization. Upon withdrawal, my photographs and / or video, in whole or in part as requested by me, will be removed from any and all electronic media. Photographs published in print by Dr. Reilly, ASPS, or another publisher prior to the date of my retirement will not be affected by my retirement. Photographs printed by third parties from an electronic format before my retirement will not be affected by my retirement either.

My photographs may be considered private medical information. It is my right to refuse to authorize the release of my private medical information. Denying my authorization to release my private medical information will prevent disclosure of such information but will never affect the quality of care I receive from Dr. Reilly. It is my right to inspect and copy all information I have authorized to disclose. It is also my right to revoke this written authorization at any time and will have no effect on the medical care I receive.

I understand that the information disclosed, or any part thereof, may be protected by state law and / or the 1996 Federal Health Insurance Portability and Accountability Act (HIPAA). In addition, I understand that, because ASPS is not receiving the information in its capacity for a HIPAA

covered medical or health care plan, the information described above may not be protected by HIPAA.

I release Dr. Reilly, ASPS, YouTube, RealSelf or any other organization in possession of my photos and all parties acting under his license and the authority of all rights that he may have on the photographs and any claims he may have related to such use in the publication, including the request for payment in connection with the distribution or publication of the photographs.

I certify that I have read this Authorization and Release and fully understand its terms.

Signed: Date:

I have read the Authorization and Release above. I am the parent, representative or guardian of _____, a minor. I am authorized to sign on your behalf and grant this authorization voluntarily.