MEDIA RELEASE CONSENT

Media Release Consent:

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I ______________________________ hereby authorize Pinnacle Plastic Surgery Associates, LLC to disclose my pre-op and post-op photographs, age, gender, description of prosthesis and technique used from my recent procedure. I fully understand that my protected health information is to be used on or in any affiliated related media outlets for advertising and testimonial purposes.

This authorization shall be in force and effect until, at which time this authorization to use or disclose this protected health information expires.

I understand I have the right to revoke this authorization, in writing, at any time by sending such written notification to the office manager at Pinnacle Plastic Surgery Associates, LLC. I understand that a revocation is not effective to the extent that Pinnacle Plastic Surgery Associates, LLC has relied on the use or disclosure of the protected health information.

I understand that if information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and my no longer be protected by federal or state law.

Pinnacle Plastic Surgery Associates, LLC will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
- Refuse to sign this authorization
- Receive a signed copy of this authorization.

Signature: ____ Date: ________________________