



# Ohio Plastic and Reconstructive Surgery LLC

112 Morey Dr., Marysville, OH 43040

## PATIENT PHOTOGRAPHY AND STATEMENT CONSENT AND RELEASE

Patient Information	Name _____			Date of Birth: ____/____/____
	Last	First	Middle	

I understand that for purposes of my treatment (as well as for education, training, and research) Ohio Plastic and Reconstructive Surgery LLC (OhioPRS) (and its staff) will take photographs (including video and still photographs, in digital and other formats) of me or parts of my body before and after treatment ("**Photographs**") and will record and transcribe my statements regarding the treatment and services rendered to me by Stephen Poteet and staff ("**Statements**"). I also understand that all such Photographs and Statements are the sole and exclusive intellectual property of OhioPRS and, to the extent I have any rights therein, I transfer and assign to OhioPRS all such rights and ownership interests.

By executing this Consent and Release, I give OhioPRS my consent to use the Photographs and Statements for the additional purposes of public relations and/or advertising. I understand that I am not required to sign this Consent and Release as a condition to receiving health care treatment from OhioPRS. I acknowledge and agree that in giving my consent, OhioPRS may display the Photographs and Statements (in whole or in part or in combination) within the office, on its website and in promotional materials including in print, or broadcast media, newspapers, pamphlets, educational films, on the internet and via television, in order to inform the public about OhioPRS services and methods. By executing this Consent and Release I authorize OhioPRS to do so and to capture, use, reproduce and distribute the Photographs and my testimonial Statements together with my voice, image, picture, likeness ("**Likeness**") for such purposes.

I hereby irrevocably consent to and authorize the use and reproduction by OhioPRS and its affiliates, or anyone authorized by any of them, of any and all photographs, electronic images, or video footage of me taken by OhioPRS, or that OhioPRS has in its possession, provided either by me or by a third party (collectively, Images) for the purpose of informing the medical profession and the general public about plastic surgery and plastic surgery procedures and techniques. Such use shall include, but not be limited to, distributing the Images via print, visual, and electronic media, specifically including the ASPS website and social media sites such as, but not limited to, YouTube, Facebook, Instagram, Snapchat, Tiktok and Twitter. The Images (including any photographic negatives) shall be the sole property of OhioPRS. OhioPRS also shall have the right to use my name in connection therewith if it so chooses.

I hereby waive any right to inspect or approve the finished product, photograph, video, DVD, CD-ROM, or matter that may be used in conjunction therewith or to the eventual use that it might be applied. I hereby release, discharge, and agree to hold harmless OhioPRS and Dr. Poteet and its affiliates and their respective representatives, assigns, and employees, and any person acting under their permission or authority, from and against any claims whatsoever in connection with the use of my Images and name and the reproduction thereof as stated above, including any claim for payment in connection with distribution or publication of the video and/or photographs.

I hereby warrant that I am over eighteen years of age and competent to contract in my own name insofar as the above is concerned. By signing this Consent and Release, I acknowledge my consent to the above and represent and warrant that: Statements I have provided to OhioPRS reflect my actual experience with OhioPRS and my honest opinions about its services; and that I have read and understand the contents of this Consent and Release and agree to all of its terms. I agree that this Consent and Release supersedes any prior Photography and Statement consent form I may have signed.

I have read and understand the foregoing release, authorization, and agreement and enter into it knowingly and voluntarily.

Signature: \_\_\_\_\_

Date/Time: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Signature of guardian (if patient is a minor): \_\_\_\_\_

I consent to photographs for educational and treatment purposes but not to electronic social media sites (including YouTube, Facebook, Instagram, Snapchat, Tiktok and Twitter).

Signature: \_\_\_\_\_

Date/Time: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Signature of Guardian (if patient is a minor): \_\_\_\_\_