AUTHORIZATION FOR USE AND DISCLOSURE
OF MEDICAL PHOTOGRAPHS
ON TOC EYE AND FACE WEBSITE AND/OR SOCIAL MEDIA

Name: _____

I authorize **TEXAS OCULOPLASTIC CONSULTANTS** ("Texas Oculoplastic") to use and disclose my Protected Health Information for a purpose other than treatment, payment, or healthcare operations. By signing this form, I authorize Texas Oculoplastic to take my Pre- and Post-Operative photographs to use on their website or social media platforms to enable prospective patients to see samples of our work in order to decide if they wish to receive our services. I authorize Texas Oculoplastic to utilize such photographs in any and all manner and media available. The term "photograph" as used in this Authorization includes motion picture or still photography in any format, as well as videotape, video disc, and any other means of recording and reproducing images. I understand that the use and/or disclosure of my photographs may occur electronically and I authorize electronic disclosure.

I understand that the purpose of this Authorization is to permit Texas Oculoplastic to use my photographs for their marketing and promotional activities. I specifically authorize Texas Oculoplastic to use and disclose my photographs as part of its advertising, marketing, or other promotional campaigns, including but not limited to its website gallery, social media, interviews with news media, brochures, or television commercials (cumulatively, "Program").

I understand that by participating in the Program, the following may be used and disclosed:

(This list serves only as an example of the type of information that may be disclosed.)

- Photographs or images of my face before and after surgery;
- My voice;
- My diagnosis;
- My medical data/information as related to my specific condition and surgery;
- Any biographical material about me in connection with the recording.

I understand that this information will be disclosed to the general public. I am comfortable with such disclosure and understand that Texas Oculoplastic may, in its sole discretion, edit my photograph, or image and combine it with other patients who have their services. I understand that when information is used or disclosed pursuant to this Authorization it may be subject to re-disclosure by the recipient(s) and may no longer be protected by state or federal privacy regulations.

REVOCATION

I UNDERSTAND I HAVE A RIGHT TO REVOKE THIS AUTHORIZATION. SHOULD I DESIRE TO REVOKE THIS AUTHORIZATION, I MAY DO SO IN WRITING, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE OF THIS AUTHORIZATION.

I UNDERSTAND THAT ONCE MY PHOTOGRAPHS OR IMAGES BECOME PART OF A MOTION PICTURE, VIDEOTAPE, VIDEO DISC, OR OTHER ELECTRONIC RECORDING THAT I WILL NOT BE ABLE TO REVOKE THIS AUTHORIZATION AND THAT THEY WILL BECOME A PERMANENT PART OF TEXAS OCULOPLASTIC CONSULTANT'S WEBSITE AND/OR SOCIAL MEDIA. TEXAS OCULOPLASTIC CONSULTANTS CANNOT RETRACT BROADCASTING OR OTHER DISCLOSURES THAT HAVE ALREADY OCCURRED.

IN ORDER FOR MY REVOCATION TO BE EFFECTIVE, TEXAS OCULOPLASTIC MUST RECEIVE THE REVOCATION IN WRITING. ALL REVOCATIONS MUST BE SENT TO THE ABOVE ADDRESS AND INDIVIDUAL AND ARE NOT EFFECTIVE UNTIL RECEIVED.

ADDITIONAL INFORMATION

I understand that I am under no obligation to participate in the Program and am not required to sign this form. I understand that I am not entitled to monetary payment or any other consideration as a result of my participation in the Program. I further understand that Texas Oculoplastic may not condition my treatment, payment, enrollment, or eligibility for benefits based on whether I sign this Authorization.

I release Texas Oculoplastic, its agents, employees, licensees, and assigns from and against any and all claims and liability which I have or may have against Texas Oculoplastic for disclosure of confidential information, invasion of privacy, defamation, or any other cause of action arising out of production, distribution, broadcast, or exhibition of my photographs.

I fully understand and accept the terms of this Authorization. I have read this Authorization and understand what information may will be used and disclosed, who may use and disclose the information, and the recipient(s) of that information. I acknowledge Texas Oculoplastic has answered all my questions to my satisfaction and that I am entitled to receive a copy of this Authorization.

Signature of Patient/Legal Representative	Date
Witness	Date