american surgical arts
plastic & reconstructive surgery
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PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I, Authorize Dr. Sean Bidic and/or Dr. Vinay Gundlapalli, and/or Dr. Casey Sheck and/or his representative(s) to take photographs, slides or videotapes of me or parts of my body for the following procedure(s) and for medical purposes to be used for my care, medical presentations and/or articles.

In addition, I authorize the use of these images, without compensation to me, for the following specific purposes: (please initial in the boxes marked yes or no for each item). Note that identifiers will not be used in any medium

Yes	No	Medium
		In the office photo albums for prospective patients
		In the office seminars for prospective patients
		On our website and/or social media for prospective patients
		In Print advertisements
		On Television

I understand that:

1) Such photographs, slides or videotapes may be published by Dr. Sean Bidic and/or Dr. Vinay Gundlapalli, and/or Dr. Casey Sheck and/or any American Surgical Arts authorized employee in any print, visual or electronic media including, but not limited to Medical journals and textbooks, scientific presentations and teaching courses, and Internet websites, for the purpose of informing the medical profession or the general public about plastic surgery methods. I understand that such uses may include marketing on behalf of American Surgical Arts for which American Surgical Arts may receive direct or indirect renumeration.
2) I will not be identified by name in any of the media described above however, I also understand that in some circumstances the photographs, slides or videotapes may display features that identify me.
3) I have the right to revoke this authorization in writing at any time and if decide to do so, must present my written revocation to American Surgical Arts, 199 Mullica Hill Rd, Mullica Hill, N.J. 08062. A revocation shall not affect any release of information made prior to revocation in reliance upon this authorization. If I do not revoke this authorization, it will not expire. If fail to specify an expiration date, event or condition this authorization will not expire. I may refuge to Sign this authorization without such refusal affecting the medical treatment I receive from Dr. Sean Bidic and/or Dr. Vinay Gundlapalli, and/or Dr. Casey Sheck.
4) The information disclosed under this authorization* or some portion thereof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996(HlPAA)any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by applicable federal and/or state Confidentiality rules.
5) A copy of this Authorization is valid as the original. I may inspect or copy information used or disclosed under this authorization, as provided by federal and/or state laws

Sean M. Bidic, MD, MFA, FAAP, FACS
Board Certified Plastic Surgeon
Board Certified Hand Surgeon

Casey G. Sheck, DO
Board Eligible Plastic Surgeon
Board Certified General Surgeon

Vinay Gundlapalli, MD, FACS
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I release and discharge Dr. Sean Bidic and/or Dr. Vinay Gundlapalli, and/or Dr. Casey Sheck and/or and/or American Surgical Arts from all liability, including liability of negligence, that in any way arises out of:

1) Any rights that I may have had in photographs, slides or videotapes of me that I have authorized to be used and disclosed in this Authorization
2) Any claim that I may have had relating to such use and disclosure of those photographs, slides or videotapes of me, including any claim for payment in connection with any distribution or publication of them in any medium.

In addition:

I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing, and/pr certifying purposes by The American Board of Plastic Surgery, Inc.

This Authorization is made as a voluntary contribution in the interest of public education, and I certify that I have read this Authorization and Release carefully and understand its terms.

___ The patient is a minor, and we, the undersigned, are parent(s) or legal guardian(s) of the patient and do herby consent for the patient.

Signature _____ Date: _____

Witness _____ Date: _____

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