Cascadian Plastic Surgery PLLC
Jungwon Genevieve Park, MD, PhD
14 N Mission St Ste 201
Wenatchee, WA 98801
(509) 596-0096

PHOTOGRAPHY AND VIDEO AUTHORIZATION CONSENT

Cascadian Plastic Surgery PLLC

SECTION A – CLINICAL PHOTOGRAPHY AND MEDICAL RECORD USE

I authorize my physician, staff, and affiliated healthcare providers to obtain and use Images for purposes related to my medical care, including:

- Documentation of my condition and treatment
- Treatment planning and surgical assessment
- Monitoring treatment progress and outcomes
- Communication among healthcare providers involved in my care
- Healthcare operations as permitted by law

I understand that these Images will become part of my confidential medical record and will be maintained and protected in accordance with applicable federal and state privacy laws, including HIPAA. I understand that refusal to permit clinical photography may limit my physician's ability to document my care and surgical outcomes.

SECTION B – PROFESSIONAL AND EDUCATIONAL USE (OPTIONAL)

I authorize the use of my Images for professional and educational purposes, including:

- Medical education and training
- Professional presentations and conferences
- Scientific publications and journals
- Peer review and quality improvement activities

I understand that reasonable efforts will be made to protect my identity. However, complete anonymity cannot be guaranteed, as recognizable features may remain visible.

Please select one:

☐ YES, I authorize professional and educational use of my Images.

☐ NO, I do not authorize professional and educational use of my Images.

SECTION C – MARKETING AND PUBLIC USE (OPTIONAL)

I authorize the use of my Images for marketing and public communication purposes, including:

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- Practice website
- Before-and-after galleries
- Social media platforms
- Printed brochures and promotional materials
- Advertising and marketing campaigns

I understand that Images released publicly may be viewed, copied, shared, or redistributed by others beyond the control of the practice.

I understand that reasonable efforts may be made to conceal my identity, but complete anonymity cannot be guaranteed.

Please select one:

☐ YES, I authorize marketing and public use of my Images.

☐ NO, I do not authorize marketing and public use of my Images.

REVOCATION OF AUTHORIZATION

I understand that I may revoke the authorization granted in Sections B and C at any time by submitting a written request to the practice. Revocation will not apply to uses or disclosures that have already occurred in reliance upon this authorization. Images already published, distributed, or incorporated into educational materials may not be retrievable.

By signing this form, the personal health care information I relay or allow to be relayed to an outside source, such as a social media platform or news source, is no longer protected by state and federal privacy laws and may be re-disclosed by that source.

NO CONDITION OF TREATMENT

I understand that my decision regarding Sections B and C is entirely voluntary. My decision to authorize or decline these uses will not affect my access to treatment, payment for services, or the quality of care I receive. I will not receive compensation for my participation.

EXPIRATION

Unless revoked in writing, the authorizations granted in Sections B and C shall remain in effect indefinitely.

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ACKNOWLEDGMENT

I , _____, have read and understand this Photography and Video Authorization. I understand that photographs, video recordings, and/or digital images ("Images") may be taken before, during, and after my treatment or surgical procedure. I have had the opportunity to ask questions and receive satisfactory answers. I voluntarily authorize the uses indicated above.

Patient Signature: _____ Date: _____

Parent/Guardian (if applicable): _____ Date: _____

Relationship to Patient: _____

Witness/Staff Signature: _____ Date: _____