

HEARTLAND COSMETIC SURGERY

David A. Hendrick, M.D.

HEARTLAND COSMETIC AND RECONSTRUCTIVE SURGERY

Record of Authorization for Taking and Publication of Photographs or Images

In connection with the medical services, which I am receiving from my physician, David A. Hendrick, M.D., I consent that photographs, including digital or video images, may be taken of me or parts of my body under the following conditions:

- A. The photographs or images may be taken only with the consent of my physician and under such conditions and at such time as may be approved by him.
- B. The photographs or images shall be taken by my physician or by an assistant or photographer approved by my physician.
- C. The photographs or images may be utilized by David A. Hendrick, M.D. in the following manner, so long as my identity is not made known: medical records (patient chart); medical research, education or science; professional journals or medical books; Dr. Hendrick's office literature, speaking engagements, Internet web site, consultation booklet; and instructional booklets; public relations purposes including use in newspapers, magazines, brochures, Internet web site and TV appearances for public interest and information.

The undersigned grants to Dr. Hendrick the ongoing and unrestricted right to use those photographs for general information, education, scientific, medical and public relations purposes and to permit others to use them for those purposes.

The undersigned acknowledges that he/she relinquishes all right, title and interest in these photographs or images or any right to profit or gain directly or indirectly realized through the use of the photographs or images. The persons to whom disclosure may be made include physicians, medical students, patients and prospective patients, examining boards, medical and other periodicals, medical editors, insurers (if any), outside firms, readers of medical literature and the general public.

This consent and authorization may be revoked at any time but can only be revoked in writing, signed by the undersigned and delivered to Dr. Hendrick. Such revocation shall thereafter be effective as to any further use not already committed to by Dr. Hendrick. Unless earlier revoked, this authorization will expire on the end of Dr. Hendrick's practice of surgery, except there will be no expiration for the purpose of medical or scientific research. Revocation will not affect uses and disclosures made before receipt of the revocation. If the photographs are disclosed, there is obviously potential for re-disclosure some of which would not be subject to this authorization. This consent and authorization is in consideration of services performed and consultations conducted or to be performed or conducted by Dr. Hendrick. There have been no representations or inducements concerning this consent except as set forth herein.

Signed: _____(Patient) _____(Date)

Witnessed: _____

AUTHORIZATION BY PARENT OR GUARDIAN

I am the parent or guardian of _____, a minor. I am authorized to sign this authorization on his/her behalf, and I agree on my own behalf and his/her behalf to the terms of the foregoing authorization.

Parent/Guardian _____(Date)