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PATIENT PHOTOGRAPHIC CONSENT AUTHORIZATION AND RELEASE

I, _____ consent to the taking of photographs, videotapes, or medial images, xrays, scans of me, parts of my body, by Dr. Ali Ashraf and his medical team, of his designee, in connection with the surgical procedures involving the extremities performed by Dr. Ashraf and his staff. I understand that such photographs, videotapes, medical images, xrays, scans or case histories may be published by Dr. Ashraf in print, visual or electronic media including, but not limited to, medical journals and textbooks, scientific presentations, teaching courses, social media, and internet web sites for the purpose of informing the medical profession or the general public about orthopaedic surgery. Neither I, nor any members of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that shall make my identity recognizable. I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire twenty (20) years from the date written below. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Dr. Ashraf. I understand that the information disclosed, or some portion thereof, may be protected by law and/or the federal Health Insurance Portability and Accountability Act of 1996 (“HIPPA”). I release and discharge Dr. Ashraf, and all parties acting under his license and authority from all rights that I may have in the photographs, videotapes, medical images, xrays, scans or case histories and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of these materials in any medium. I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

Patient_____ Date_____

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