Patient Name: _____

Photographic Release Form for Treatment Plan & Medical Records

I authorize Dr. J. Alex Kelamis and/or Kelamis Plastic Surgery, PLLC, and/or [his/her/their] 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, specifically for medical records.

Procedures: All reconstructive surgery, all cosmetic surgery, and all non-surgical cosmetic procedures (eg--Botox, dermal fillers, chemical peels, LASER therapy, all "aesthetic" treatments).

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 ("HIPPA"). 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.

A copy of this Authorization is valid as the original. I have received a copy of this Authorization. I may inspect or copy information to be used or disclosed under this Authorization, as provided by federal and/or state law.

I release and discharge Dr. J. Alex Kelamis and/or Kelamis Plastic Surgery, PLLC, from all liability, including liability for negligence, that in any way arises out of any and all rights that I may have or may have had in the photographs, slides or videotapes of me that I have authorized to be used and disclosed in this Authorization.

This Authorization is made as a voluntary contribution in the interest of public education and certifies that I have read this Authorization and Release carefully and fully understand its terms. If I have questions about the use or disclosure of my photographs, slides or videotapes, I can contact the clinic at (479) 935-3227.

Patient Signature: _____ **Date:** _____

Witness: _____ **Date:** _____