AUTHORIZATION FORM FOR THE USE AND/OR DISCLOSURE OF PHOTOGRAPHIC PROTECTED HEALTH INFORMATION TO A THIRD PARTY

1. I authorize my health care provider Christopher Lansford, MD to use and/or disclose photographs taken during my health care as described below. I understand that these photographs are considered protected health information under federal law.

2. I authorize the American Board of Otolaryngology - Head and Neck Surgery (ABOHNS) and/or the American Board of Facial Plastic and Reconstructive Surgery to use these photographs as part of their examinations.

3. I understand that I will not receive compensation for the use of such photographs, nor will I require any compensation.

4. I authorize use of these photographs for education of physicians, students, and the public, including use in print and electronic media such as on a website or social media. I understand that efforts will be made to minimize personally identifiable features.

5. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations then such information may be re-disclosed by that person or entity and would no longer be protected by those regulations.

6. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information may have already acted upon this authorization. Revocation of this Authorization will prevent future releases of information by my health care provider, but will not revoke the Boards permission to use the photographs released in reliance on this Authorization.

7. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed (in accordance with the requirements of the federal regulations found under 45 C.F.R. 164.524).

8. I understand that my health care provider cannot refuse to treat me if I do not sign this Authorization, and that I can refuse to sign without any adverse consequences.

9. I understand that a copy of this authorization form will be available to me.

10. Please sign this form and provide the required information below. You do not need to sign this form to receive health care services and your refusal to sign is not grounds for denying you any services that you would otherwise receive.

Signature:_____ Date: _____

Patient Name: _____

Name of Personal Representative:_____

Relationship to the Patient:_____