Authorization For Release And
Use Of Photographs For Peer Review

The undersigned _____, is a patient of William O'Mara, MD ("the treating physician") and has been or will be photographed during the course of treatment. (By the term of "photographs," this form also includes digital images.) Those photographs will become part of this medical record in the patient chart. Under the Health Insurance Portability and Accounting Act of 1996 (HIPAA), those photographs may be supplied as part of the medical records to medical specialty boards and hospital medical staffs reviewing the treating physician's credentials under a "Business Associated Contract" prescribed by HIPAA. In addition, the undersigned grants to the treating physician the on-going under restricted right to use those photographs (but not the patient's name) in the following way (**initial all applicable**):

_____Use by medical specialty board in formulating its examination of applicant physicians.

_____Medical research, education, or science.

_____Professional medical journals, videos, or books.

_____Patient education purposes, including the treating physician's procedural and general information brochures and photo book for prospective patient viewing.

_____Slides, computer images, website and television media providing information about physician's practice to the interested public (including public relations).

The undersigned acknowledges that the persons to whom the photographs may be disclosed for above stated purposes include other practicing physicians, medical students, health care providers, credentialing organizations (such as the American Board of Facial Plastic and Reconstructive Surgery) and their staffs. Prospective patients and the public, may, under some of the above alternatives, also view the photographs. Under HIPAA, if the organization or person authorized to receive the photographs is not a health plan or health care provider, the released information may not be covered by HIPAA's protections from further disclosures or use by federal privacy regulations.

This authorization may only be revoked in writing, signed by the undersigned and delivered to the physician at the treating physician's address below. Such revocation shall thereafter be effective as to any further use not already committed by the physician. Unless earlier revoked, this authorization will expire on the end of the treating physician's practice of facial and reconstructive surgery, except there will be no expiration for the purpose of medical or scientific research or use in specialty-board examinations. Revocations will not affect uses and disclosures made before receipt of the revocation. This authorization is in consideration of services performed and consultations conducted or to be performed or conducted by the physician, and there have been no representations or inducements concerning this authorization. The undersigned may see and copy any photographs described on this form upon request and may receive a photocopy of this authorization form upon request.

_____ _____
Signature of Patient Date

_____
Witness

AUTHORIZATION BY PARENT OR GUARDIAN

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

_____ _____
Signature of Parent or Legal Guardian Date

Facial Plastic Surgery of Beaumont
William O'Mara, M.D.