VASCULAR INSTITUTE
OF CHATTANOOGA

Release of Patient Photography

Name: _____ Date of Birth: _____

I consent to the taking of photographs by Dr. LeSar or his designee of me, or parts of my body in connection with the evaluation and/or surgical procedure(s) to be performed.

Vascular Institute of Chattanooga utilizes photographs as part of the patient record. From time to time we publish papers, books, or give presentations for medical education programs. In addition, we may utilize photographs for in office patient education, research projects or symposiums, or other events suitable for patient education. The photographs of you (or your children) will not necessarily be used for any purposes other than to document your condition in your medical record; however, we ask your permission to use them if needed as describe above.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that will make my identity potentially recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive from any provider of Vascular Institute of Chattanooga.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it will not have any effect on any actions taken prior to my revocation. Unless otherwise revoked, this authorization will expire in 12 months.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPPAA").

I release and discharge Vascular Institute of Chattanooga and all parties acting under their license and authority all rights I may have in the photographs 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 the photographs.

I certify that I have read the above authorization and release and fully understand its terms.

_____	_____	_____
Patient or Personal Representative Signature	**Date**	**Relationship to Patient**