Northwestern Medicine®

AUTHORIZATION TO OBTAIN, USE AND DISCLOSE IMAGES AND OTHER MEDIA FOR PATIENTS AND NON-PATIENTS*

By signing this form, I hereby authorize Northwestern Medical Group's Plastic Surgery Department ("Department"), an affiliate of Northwestern Memorial HealthCare ("NMHC"), to create, obtain, record use and disclose photography and/or video or audio recording in print, digital or video media ("images"). The permitted uses and disclosures of this information, images and other media may include without limitation.

- Marketing purposes, including but not limited to posting my images on my surgeon's or NMHC websites and social media (e.g., Facebook, Twitter, Instagram, etc.)
- Educational purposes, including but not limited to publications and presentations
- Credentialing purposes

I further consent to my information and images being stored and managed within NMHC for future use, unless I indicate otherwise. I hereby waive the right to receive a copy, inspect or approve the images and also waive any and all rights that I may have to any claims for payment or royalties in connection with the above use of the images and other media.

I acknowledge that the images will remain the sole property of NMHC. I also understand that NMHC is not receiving any financial or other compensation from third parties for use of the images or other media. I understand I have the right to refuse to sign this Authorization and that this Authorization is valid unless I cancel or revoke it in writing. If I choose to revoke this Authorization at any time in the future, I will send my revocation to Northwestern Medical Group Plastic Surgery at 675 N. St. Clair Street, Suite 19-250, Chicago, Illinois, 60611. My written revocation will not affect any disclosure made before the receipt of my revocation by NMHC.

I have read, understand and agree to the conditions of this Authorization by signing below.

Patient*/Individual (Non-Patient) Signature	Patient/Individual (Non-Patient) Name (Please Print)

Legal Representative Signature*	Legal Representative Name (Please Print)	Relationship	Date

Patients and Legal Representatives of Patients also must sign the AUTHORIZATION TO OBTAIN, USE AND DISCLOSE HEALTH INFORMATION FOR PATIENTS form (See reverse).

AUTHORIZATION TO OBTAIN, USE AND DISCLOSE HEALTH INFORMATION FOR PATIENTS*

By signing this form, I hereby authorize the Northwestern Medical Group's Plastics Surgery Department ("Department"), an affiliate of Northwestern Memorial HealthCare ("NMHC"), to use and disclose my identifiable photographs and/or videos ("images") taken before, during, and after surgery in print, digital or video media for the following purposes.

- Marketing purposes, including but not limited to posting my images on my surgeon's or NMHC websites and social media (e.g., Facebook, Twitter, Instagram, etc.)
- Educational purposes, including but not limited to publications and presentations
- Credentialing purposes

I understand that I am not required to sign this form and that my choice about whether to sign this form will not change the way the Department treats me. The Department will not deny care to me if I refuse to sign. I understand that my once my images are disclosed pursuant to this authorization, it is possible that such material will no longer be protected by federal and state privacy laws and could be re-disclosed by any individual or entity receiving such material, including the general public.

This authorization will last for twenty (20) years from the date I sign it. If I change my mind after signing it, I can revoke it by contacting the Department, in writing, at Northwestern Medical Group Plastic Surgery Department at 675 N. St. Clair Street, Suite 19-250, Chicago, Illinois, 60611. My written revocation will not affect any disclosure made before the receipt of my revocation by NMHC.

I have read, understand and agree to the conditions of this Authorization by signing below.

_____	_____
Patient Signature	Patient Name (Please Print)

_____	_____	_____	_____
Legal Representative Signature	Legal Representative Name (Please Print)	Relationship	Date

Patients whose information and images are to be released must sign this form in addition to the AUTHORIZATION TO OBTAIN, USE AND DISCLOSE IMAGES AND OTHER MEDIA FOR PATIENTS AND NON-PATIENTS form (see reverse).