Plastic and Reconstructive Surgery & PRS Global Open

Rod J. Rohrich, M.D., Editor-in-Chief
Brookriver Executive Center
8150 Brookriver Drive
Suite S-415
Dallas, TX 75247

PATIENT VIDEOGRAPHIC AUTHORIZATION AND RELEASE

I consent to the taking of video footage by Dr. Downs or his designee of me or parts of my body in connection with the plastic surgery procedures(s) to be performed by Dr. Downs. I further consent to the release by Dr. Downs to the American Society of Plastic Surgeons ("ASPS") of such video footage.

I understand that such videos, or video captures, may be published by ASPS and/or any party acting under the license and authority of ASPS in any print, visual, electronic, or broadcast media, specifically including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses and Internet websites, for the purpose of informing the medical profession or the general public about plastic surgery methods, results, issues, trends, concerns and similar matters. I further understand that the imaging records shall become the property of ASPS.

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

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire ten years from the date written below. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Dr. Downs.

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 ("HIPAA"). I further understand that, because ASPS is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA and may be redisclosed by ASPS.

I release and discharge Dr. Downs, ASPS, and all parties acting under their license and authority from all rights that I may have in the video footage 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 video.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

Patient Norene Smith *Date* 12.14.15

WITNESS/PHYSICIAN: _____

I have read the above Authorization and Release. I am the parent, guardian or conservator of _____, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

Parent/Guardian _____ *Date* _____