Weill Cornell Medicine

**Department of Otolaryngology –
Head and Neck Surgery**

Anthony Sclafani, MD

CONSENT FOR PHOTOGRAPHY

I, the undersigned, _____, am a patient of Anthony P. Sclafani, MD and consent to be photographed (film and digital media- still photographs and video) as relates to my treatment. This may be performed before, during or after treatment, in either the physician's office or operating room.

I understand that Dr. Sclafani, where applicable, may frequently obtain before and after clinical photographs. While these photographs are primarily used to improve and optimize the communication between you and Dr. Sclafani, he may occasionally also depend on the ability to share this clinical photographic information with your referring physician(s), insurance companies and others. Furthermore, such information is vitally needed to increased and advance medical education and research.

In the course of consultation and discussions with Dr. Sclafani and his staff, I may be shown or provided certain brochures, pictures of actual patients or pictures of myself on an electronic imaging device. I do understand that those pictures and alterations of these pictures seen are solely for the purpose of illustration, discussion and to provide improved communications with medical professionals. I do understand that the outcome of any type of surgical procedure is directly related to my individual characteristics and health. I further understand and acknowledge that because of the obvious significant differences in how living tissues react to surgery, there may be no relationship between the electronic images created, and my actual final surgical result. Use of the computer imaging system offers an opportunity for me to discuss my desires and to allow improved communication with the medical staff.

I certify my understanding that there is NO WARRANTY, expressed or suggested, as to my own final appearance after elective surgery by the use of these electronically altered images.

The undersigned grants to Dr. Sclafani the on-going and unrestricted use of the undersigned's photographs and altered electronic images for general information, education, scientific and medical purposes at any time during or after treatment, with complete confidentiality of the my identity.

The undersigned further acknowledges that he/she relinquishes all right, title, and interest in these photographs, or any right to profit or gain directly or indirectly realized through the use of these photographs. I release Dr. Sclafani, his agents, employees, licensees and assigns from any and all claims I may have now or in the future for invasion of privacy, right of publicity, copyright infringement, defamation or any other cause of action arising out of the use, reproduction, adaptation, display or transmission of this material. I waive any right to inspect or approve any works that may contain these materials. The persons to whom disclosure may be made include physicians, medical students, patients and prospective patients, examining boards, medical or other periodicals, medical editors, insurers (if any), outside firms, the staff of the American

Academy of Facial Plastic & Reconstructive Surgery (AAFPRS) and the AAFPRS Foundation or other academic/scientific organization, readers of medical literature and the general public.

This consent may only be revoked in writing, signed by the undersigned and delivered to Dr. Sclafani at his office. Such revocation shall thereafter be effective as to any further use not already committed to by Dr. Sclafani. Unless earlier revoked, this authorization will expire on the end of the treating physician's practice of facial plastic surgery, except there will be no expiration for the purpose of medical or scientific research. Revocation will not affect uses and disclosures made before receipt of the revocation. If the photographs are disclosed, there is obvious potential for redisclosure some of which would not be subject to this authorization. This consent is in consideration of services performed and consultations conducted or to be performed or conducted by Dr. Sclafani, and there have been no representations or inducements concerning this consent except as set forth herein. The treating physician will not condition treatment on whether the individual signs this authorization, but if any portion of the treating physician's services is to be covered under any insurance or third-party payment plan, the signing individual will be responsible for authorizing release as required by that insurance or third-party payment plan.

I provide this authorization as a voluntary contribution in the interests of public education.

Patient Name:

Signature: **Date:**

(Patient or Responsible Party)