90210 Surgical Associates

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CONSENT/AUTHORIZATION

I, _____ irrevocably consent/ authorize Dr. Fadi Chahin, or representative to take photographs, slides, or videos of me for medical purposes to be used for my care, medical presentation, articles, marketing, web based and electronic marketing, social media (i.e. Facebook, Instagram, Twitter, Snapchat ect.) and/ or other fair public uses. I understand that the above consent/ mentioned items will be part of my medical records and therefore subject to Dr. Fadi Chahin and/or representative's discretion for fair use.

If in the judgment of my physician, medical research, education or science will benefit by their use, the photographs and other information, such as described herein, relating to my case may be published and republished in professional journals or medical books, or used for any other purposes which he/she may deem proper in the interest of medical education, knowledge, or research. I understand that in any such publication or use I shall not be identified by name.

Additionally, I hereby authorize permission for the use of any of my medical records, illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing, and/or certifying purposes by The American Board of Plastic Surgery, Inc.

At my physician's discretion, the photographs or other information described herein, may be used in the office photo album, seminars, or in any other way Dr. Chahin and/or representative desires to do so, on our website for perspective patients without any kind of compensation whatsoever to the patient or undersigner. The photographs may also be published in periodicals and or newspapers including those with general circulation, or used in video, television, slide presentations or other print or electronic medical with no compensation of any kind whatsoever to the patient or undersigner.

The patient/undersigner acknowledges/understands waiving any legal rights/privileges may have including but not limited to rights of privacy, HIPPA and any other legal rights as to the matters stated herein this consent/ authorization. If the patient/undersigner's primary language is anything other than English, this consent/ authorization has been explained to him/her prior to signing

If used for medical purposes, the photographs or other information described herein may be modified or retouched in any way that my physician in his discretion, may consider desirable.

I have read, understood, and agreed with this irrevocable consent/authorization in its entirety:

Patient or Guardian Signature _____ Date _____

Witness Signature _____

A photo copy is valid as the original

This consent can be revoked at any time with a written request