VANTAGE
PLASTIC SURGERY

Imaging Records Authorization and Release Consent

Patient name: DANIELS KAMILIOTIS **Date:** 1/9/24

✓ I understand that Dr. Shteynberg and/or his designee will take photographs of me or parts of my body in connection with the plastic surgery procedure(s) to be performed on me by Dr. Shteynberg. These are for my medical record as well as research or educational purposes.

✓ I consent to the release by Dr. Shteynberg and Vantage Plastic Surgery PLLC, of these photographs for use in any print, visual, or electronic media, specifically including, but not limited to, professional medical journals and textbooks, or any other commercial or non-commercial purpose deemed proper and professionally appropriate by Dr. Shteynberg.

✓ I hereby understand that this authorization for release of my photographs and other imaging records will be done with the discretion of Dr. Shteynberg, and that in any such case no identifying information, including but not limited to, my name, medical record number, social security number, date of birth, health insurance information, or payment amount and methods, will be published in conjunction with these photos. I do understand, however, that in some circumstances the photographs 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 will not have any effect on any actions taken prior to my revocation. I understand that I may refuse to sign this authorization, and that such refusal will have no effect on the care I receive from Dr. Shteynberg or Vantage Plastic Surgery PLLC.

✓ I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I release and discharge Dr. Shteynberg and Vantage Plastic Surgery PLLC, and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including but not limited to, any claim for payment in connection with distribution or publication of the photographs.

I, have read the above Photographic Authorization and Release Consent form, and understand each part of it. Dr. Shteynberg or his designee has thoroughly explained all aspects of this form to me, and has satisfactorily answered all of my questions pertaining to it. I hereby consent, and acknowledge my agreement to the terms set forth in this document. Should any subsequent changes in the practice policy of Vantage Plastic Surgery PLLC occur, I understand that this consent shall remain in force from this time forward until any changes to this policy are made and notified to me.

Patient Signature: Daniels Kamiliotis **Date:** 1/9/24

Witness Signature: [signature] **Date:** 1/9/24

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