GEORGE MATSUDA, M.D. | DIAMOND COSMETIC GYNECOLOGY
Photographic/Videographic Documentation Consent Form

I consent to the taking of photographs or videotapes of myself or my body by Diamond Cosmetic Gynecology, Dr. Matsuda, or his designee, in connection with any and/or all medical spa or plastic surgery procedure(S)

I understand that photographs may be required by my insurance company for the purpose of prior authorization and consent to the release of ant requested images for this purpose.

I understand that such photographs, videotapes, or case histories may be published by Diamond Cosmetic Surgery.

Neither I, nor any member of my family, will be identified by name in any publication or on the website. I understand that in some circumstances the photographs may portray features that 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 have no effect on any action taken prior my revocation. If I do not revoke this authorization, it will expire twenty (20) years from the date writes 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 Diamond Cosmetic Gynecology.

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 ("HIPP")

I release and discharge Diamond Cosmetic Gynecology and all parties acting under this license and authority from all right that I may have in the photographs, videotapes, or case histories 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 these materials in any medium.

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 it's terms.

Signature: _____ Date: _____

Patient Name: _____