PROF CHRYSIS SOFIANOS
PLASTIC & RECONSTRUCTIVE SURGEON

MBBCh (Wits), MSc (Ed), FC Plast Surg (SA),
MMed (Wits), FRCS Plast, FEBOPRAS, FACS
Practice Nr - 0755281
www.cs.surgery
+27 (0)10 500 5151 info@cs.surgery

Informed Consent for the use of Patient Photographs and Video in Social Media

I _____ understand that photographs and/or videos may be taken of me or parts of my body before, during, and after surgery and the consultation process. These images may be shared with staff, other physicians or health professionals as part of the treatment process. These may also be shared with members of the public for educational and marketing purposes in line with the consent provided below.

I hereby give my consent for Prof. Chrysis Sofianos to use the photographs under the following circumstances:

Please select JUST ONE of the following:

☐ **I OPT OUT:** I do not want my photographs to be used for advertising/marketing. I understand these will still be retained as part of my medical record and may be shared with medical aid or other professionals or for education within the practice.

☐ **EDUCATIONAL PURPOSES ONLY:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received may be used for scientific/ academic presentations, scientific publications and academic journal articles or as part of academic discussion groups, in order to inform and educate other health professionals or plastic surgeons.

☐ **PRACTICE WEBSITE ONLY:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received may be used on our website without disclosure of personal information in order to inform the public about plastic surgery methods. I understand that once these images are placed on a digital platform, they can be altered and archived, and are permanent, and searchable.

☐ **ALL MEDIA EXCLUDING SOCIAL MEDIA:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received may be used in any print or broadcast media, including but not necessarily limited to newspapers, pamphlets, educational films, practice website, and television, in order to inform and educate the public or other physicians about plastic surgery.

☐ **ALL MEDIA INCLUDING SOCIAL MEDIA:** Photographs and/or videos taken of me or parts of my body as well as details regarding medical services that I have received may be used on social media sites, including but not necessarily limited to Facebook, Instagram, Snapchat, Twitter, RealSelf, (Whatsapp) and other outlets, in order to inform the public or other physicians about plastic surgery. ***I understand that once my images are published, I lose control and rights to these images. I understand that once my images are published, the individual social media platforms may assume control and rights to those images. I also understand that images posted on the Internet can be altered and/or archived, and are permanent and searchable.***

REVOCATION: I understand that I may revoke this authorization at any time; however, such revocation must be in writing and received via email or registered mail. Revocation affects disclosure moving forward and is not retroactive.
EXPIRATION: This authorisation continues indefinitely until such time as I revoke it.
VOLUNTARY CONSENT: I understand that my participation is voluntary. If I do not sign this form, my healthcare and payment for my healthcare will not be affected. This consent covers media only for marketing or advertising. It excludes the consent that has already been provided for any photographs or videos taken as part of the consultation and treatment process provided by Prof Sofianos. These are stored as part of my medical chart for record-keeping and shared as necessary.

I will not receive compensation for my participation.

By signing this form, the personal health care information I relay or allow to be relayed to an outside source, such as social media platform or news source, is no longer protected by privacy laws and may be re-disclosed by that source.

Before signing this document, I have considered my decision carefully.

Patient or Guardian Signature:		ID Nr:	
Patient Name:		Date	