HIPAA Authorization and Consent to Photograph/Collect Ultherapy® Treatment-Related Information and Publish Without Identification By Name (the Authorization)

I _____, hereby authorize James D. Wethe, MD and/or whomever he may designate as his assistant(s), to use and disclose photographs, films, illustrations or video ('media') and Ultherapy® treatment-related information, taken or collected in conjunction with my Ultherapy® treatment on or about _____, 20____, all of which include information considered 'protected health information' (PHI) under the Federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

I authorize Dr. Wethe, at his sole discretion, to use and disclose the media and Ultherapy® information on his website, in printed brochures, news releases, videos, television, social media and other media marketing materials for any bona fide business purposes, including, but not limited to, dissemination to employees, clients, health professionals or members of the general public for education, research, scientific, public relations, marketing, or advertising in any form of media, and that such dissemination may be accomplished in any manner deemed appropriate by Dr. Wethe. Such purposes may include showing actual patient results with Ultherapy® through the use of 'before and 'after' photographs. I understand that once so used and disclosed, Dr. Wethe has no control or responsibility over how the media will be used or further disclosed. Neither I, nor any member of my family, will be identified by name in connection with the media or Ultherapy® treatment information at any time.

If I have any questions regarding the Authorization, I should call Dr. Wethe at 310-784-8389.

I understand that I have the right to revoke this Authorization at any time, and in order to do so, I must send written notification to James D Wethe MD at 3440 Lomita Boulevard, Suite 220, Torrance, CA 90505.

Please initial ONE of the following options:

_____ Yes, I agree to the terms of the Authorization above.

_____ Yes, I agree to the terms of the Authorization above under the following conditions:

_____

_____

_____ No, I do not want my photographs to be used for purposes other than my treatment record.

_____	_____	_____
Patient or Guardian Signature	Print Name/Relationship	Date
_____	_____	_____
Witness or Representative Signature	Print Name	Date