***Receipt of Notice of Privacy Practices***

***Acknowledgment of Receipt of Notice of Privacy Practices***

***Salman Ashruf, M.D., P.A.***

***My signature on this form indicates that I have been made aware of a Notice of Privacy Practices for Salman Ashruf, M.D., P.A. If you have any questions, please contact the Privacy Officer whose name and contact information is listed below.***

___________________________________________
***Name of patient or Personal Representative (printed)***

___________________________________________
***Signature of patient or Personal Representative***

___________________________________________
***Date***

___________________________________________
***Personal Representative's Relationship or Authority***

***Privacy Officer***
***Salman Ashruf, M.D., P.A.***
***1600 S. Crain Highway***
***Suite 509***
***Glen Burnie, MD 21061***

## SALMAN ASHRUF MD, PA

***INFORMED CONSENT - PHOTOGRAPHIC RELEASE***

I understand and accept that I may be recognized from my likeness or case history. Nevertheless, I authorize Dr. Ashruf to use my photographs, videotapes, and case information in the following education and scientific settings:

- Lectures and multi-media presentations for an audience of medical professionals but at which members of the press may be present such as the **American Society for Plastic Surgeons**, the **American Association for Aesthetic Plastic Surgeons**, and the **American Association of Plastic Surgeons**
- Publication in medical, surgical and scientific journal articles and textbooks including but not limited to **Plastic and Reconstructive Surgery**, **Annals of Plastic Surgery**, **Aesthetic Surgery Journal** and **Aesthetic Plastic Surgery**

I authorize Dr. Ashruf's professional associations, including but not limited to, the not-for-profit **American Society for Plastic Surgery** and the **American Society of Aesthetic Plastic Surgeons**, to use my photographs and case information in fulfilling its mission of public education, including education brochures, video tapes, slide presentations available for purchase and case studies presented on the Societies' web sites.

I grant permission for the use of any record, illustration, photograph or other imaging record created in my case, for credentialing and/or certifying purposes by **The American Board of Plastic Surgery, Inc.**

I will allow Dr. Ashruf and his office to submit my case information and photographs to the appropriate agencies to facilitate precertification or appeal processes.

____________________________
Date

| | |
|---|---|
| ____________________________ | ____________________________ |
| Patient Signature | Witness Signature |
| ____________________________ | ____________________________ |
| Print Name | Print Name |