

Fax

To:	Renewing You Editor	From:	
Fax:	805.543.2014	Pages:	
Phone:	866.374.3762 ext. 119	Date:	
Re:	Strattice Patient Release Form	CC:	

Thank you for sharing information and photos of your successful Strattice case studies for publication on the Renewing You Web site. Please attach the patient release form, signed by the patient and the witness, and complete the section below to aid in processing. Submit one cover sheet per patient.

Physician/Practice Name: _____

Office Manager/Representative Name: _____

Mailing Address (street address only, please): _____

Phone Number: _____

Before & after photos will be delivered:

- Via email to editor@renewingyou.com (reference your practice name or Strattice account ID)
- Via postal mail to BPS Photo Processing, 751 Marsh Street, Suite B, San Luis Obispo, CA 93401
- Available on Web site at: _____

Date the photos will be sent: _____

The patient in the photo presented with the following condition(s):

- Bottoming Out
- Fold Malposition
- Symmastia
- Wrinkling & Rippling

Procedure description (optional):

Patient Release and HIPAA Authorization
(Referred to herein as the “Release”)

1. I, _____, hereby authorize LifeCell Corporation and its parents, subsidiaries, affiliates, licensees, successors and assigns (referred to collectively herein as “LifeCell”) to use and publish for the commercial and non-commercial purposes set forth below my age, height, weight, geographic location, Likeness (as defined below), general description of my medical condition and course of treatment as they relate to LifeCell products or services, and my use of LifeCell products or services (the “Content”). Such right to use, publish and copyright shall be world-wide, including the right to disclose the Content to third parties outside of my country of origin, and shall extend to all Content transmitted or displayed individually or in conjunction with other images or printed matter on the Internet-based, LifeCell sponsored website, www.renewingyou.com (the “Website”) for the purpose of advertising, promoting, illustrating, training and educating about LifeCell products or services, my physician’s utilization of LifeCell products or services, and my use of and course of treatment involving LifeCell products or services. “Likeness” is defined herein to include, pictures, drawings, photos, videos and illustrations of my breasts before and after my revision procedure (as provided by my surgeon) that show, demonstrate or illustrate the features of Strattice™ Regenerative Tissue Matrix in breast surgery for purposes of promoting and advertising. “Likeness” shall not include facial images or my name printed with any images.

2. I agree that all photographs of me used by LifeCell on the Website are owned by LifeCell and/or used with authorization of my surgeon and that it may copyright material containing same. I agree that no advertisement or other material need be submitted to me for any further approval and LifeCell shall be without liability to me for any distortion or illusionary effect resulting from the publication of the Content. I further agree and do hereby release LifeCell from any and all claims, actions, suits, agreements, liabilities or damages arising from use of the Content. I understand and agree that I will not be compensated in any way for providing the Content to LifeCell or authorizing its use in the manner detailed herein.

3. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 AUTHORIZATION (the “HIPAA Authorization”). I agree to allow LifeCell, along with the doctors, nurses and healthcare professionals who have been involved in my treatment and care related to LifeCell products or services, to use and publish my personal health information related to my use of and course of treatment involving LifeCell products or services to those things defined above as “Content” (LifeCell will not publicly disclose my name, addresses, telephone numbers, or social security number) for the commercial and non-commercial purposes outlined in paragraph 1 of this Release. The disclosure provided for in this HIPAA Authorization may be made to LifeCell or any third party recipients of the Content as described in paragraph 1 of this Release. Information disclosed or used pursuant to this HIPAA Authorization may be re-disclosed by any recipient and may no longer be protected by federal privacy laws. I understand that this HIPAA Authorization may be revoked at any time by writing to: LifeCell Corporation, ATTN: Compliance Department, One Millennium Way, Branchburg, New Jersey 08876. However, revocation will not be allowed to the extent that LifeCell has taken action based on this HIPAA Authorization. This HIPAA Authorization will expire upon its revocation by me. I understand that my treatment, payment, enrollment or eligibility for benefits may not be conditioned upon whether or not I sign this HIPAA Authorization.

Nothing herein will constitute any obligation on LifeCell to make any use of any of the rights set forth herein.

Dated: _____

Patient Name

Signature

Address

Witness Name

Signature

Address

If releasor is not yet 21 years old or if a patient representative is executing this Release on behalf of releasor, complete the following form:

I, the undersigned, hereby warrant that I am the _____* of _____, and have full authority to authorize this Release which I have read and approved. I hereby release and agree to indemnify LifeCell and their respective successors and assigns, from and against any and all liability arising out of the exercise of the rights granted by this Release.

Signature of Parent or Guardian

Witness Name

Relationship to patient or
Authority to Act

Signature

Address

Address

Date

Date

*Insert the word "parent" or "guardian," as appropriate.

[If the above signature is that of a patient's representative, the following must be completed.]

LifeCell has verified the identity of _____ by _____ *[describe means of verification, e.g., driver's license]* and that in his/her capacity of _____ *[description of authority to act, e.g., husband, wife, guardian, parent of minor, power of attorney, etc.]*, he/she is authorized to act on behalf of the patient.