
# PHOTO CONSENT AND RELEASE FORM

Patient Name: _____

I consent for photographs and/or video images to be taken of me by Snow Family Medicine, Inc. or a representative. I understand the images will be a part of my medical record and may be used for purposes of medical teaching, training and/or for marketing purposes (website, print, digital or social media).

By consenting to photographs and/or video images I understand I will not be compensated for my images by any party. Although photographs and/or video images will be used without identifiable information being listed such as name, I understand it is possible someone may recognize me.

I further acknowledge that my participation is voluntary and agree that use of any photographs and/or video images confers no rights of ownership or royalties whatsoever.

I authorize the use of photographs and/or video images: (please initial indicating YES or NO below)

_____ **YES** _____ **NO** For educational purposes

(medical teaching or training)

_____ **YES** _____ **NO** For marketing and advertising purposes

(website, print, or social media)

At my request, my photographs and/or video
images will only be used as part of my medical record.

I hereby release Snow Family Medicine, Inc, its employees, and any third parties involved in the creation of or publication of educational or marketing materials, from liability for any claims by me or any third party in connection with my participation.

By signing this form, I confirm understanding of this consent. If I wish to withdraw my consent in the future, I may do so via written request submitted to Snow Family Medicine, Inc. or by completion of a new form.

Patient Signature: _____ Date: _____