



PHOTO CONSENT FORM

- I consent to photographing the procedure(s) to be performed, including the appropriate portions of my body for medical, scientific, or educational purposes, (does not include promotional or advertising consent) provided that my identity is not revealed by the pictures.
- For the purposes of advancing medical education, I consent to the admittance of observers to the treatment room.
- It has been explained to me in a way that I understand:
 - The above treatment or procedure undertaken.
 - There may be alternative procedures or methods of treatment.
 - There are risks, known and unknown, to the procedure or treatment proposed.

Patient Name (Print)

Patient Signature

Date

Guardian Name (Print)

Guardian Signature

Date

Model Release:

In consideration for the treatment received, I hereby grant permission to the individual or company that provided my treatment to use any photographic records for the purpose of advertising or promotion (including, but not limited to: social media, print ads, online publications, websites, among others, without any additional compensation to me.

___ Yes, I consent to using before/after photos as described above without concealing my identity.

___ Yes, I consent to using my before/after photos as described, showing Treatment Area Only. Please conceal my identity.

___ No, please do not use my photos for any promotional or advertising purposes.

Patient Name (Print)

Patient Signature

Date

Guardian Name (Print)

Guardian Signature

Date

