# PATIENT PHOTO | VIDEO RELEASE

GILLIE
AESTHETICS | DERMATOLOGY

PATIENT NAME: _____ DATE : _____

This form seeks for the consent for photographs and/or videos to be taken by any employee or provider of GILLIE Aesthetics and Dermatology Plc and utilized in various methods in association with this practice and/or provider. By signing this form, the patient voluntarily affirms in understanding that the images and/or videos may be used for the different purposes indicated hereunder.

By consenting to the release of images, you agree and are aware and that you will not receive any form of money or compensation of any kind.

You likewise understand that your name will not be included in the images. Nonetheless, it is still possible that someone may recognize you. In most cases, we try to limit the identifying features of our patients, but in some instances, this cannot be avoided.

Your refusal to consent to the release of your photographs will not, in any way, affect the medical care you will receive. This consent is completely voluntary.

I authorize the use of photographs and/or videos taken of me for the following:

☐ INITIAL

Any and all purposes deemed useful by GILLIE Aesthetics and Dermatology Plc. These may include, but are not limited to social media posts, media videos, journal publications, website use, educational conferences, advertisements, public teaching, etc.

**I certify the above to be true and am authorizing GILLIE Aesthetics and Dermatology to use and display photographs and/or videos of me for the purposes above.**

SIGNATURE : _____ DATE : _____