CHANCE CHANGE

WELLNESS SPA

Patient Consent for Photography

Patient Name:_____ **Date of Birth:**_____

I, as the patient identified above or the legal representative of such patient ("**Patient**"), consent to have photographs, videotapes, digital or audio recordings, and/or images of the Patient, and any other method to reproduce or edit such Patient's likeness or image now known or hereafter developed (collectively, "**Photography**"), taken by (COMPANY NAME) and its staff (collectively "**Practice**"). I understand that such Photography will be recorded to document and assist with the Patient's care and to assist with Practice's health care operations.

I understand that the Photography or a portion of the Photography may become part of my medical record and therefore be protected, used and/or disclosed in accordance with Practice's Notice of Privacy Practices. I further understand that Practice will own the Photography and I will not receive any payment for such Photography, but that I will be allowed to access or view the Photography or to obtain copies of any portion of the Photography that becomes part of my medical record.

I have read this consent in its entirety and agree to be bound by all its terms and conditions as described above. I acknowledge and agree that I have been given the opportunity to ask any questions and had all my questions answered to my satisfaction.

Printed Patient Name **Date**	**Signature of Patient**
Practice Representative Name	**Signature of Practice Representative**