AUTHORIZATION FOR AND RELEASE OF MEDICAL PHOTOGRAPHS/SLIDES/ VIDEOTAPES

Aesthetic treatments and various medical treatments are a visually oriented specialty. As such it is necessary that medical photographs be taken before, during and after a surgical procedure or treatment. Similar to other imaging techniques like x-rays or CT scans, this allows for proper planning before procedures and follow up evaluation afterward.

Photographs are required only for the body part in question. This means that unless the planned treatment is on the face or head itself, the images typically do not include the face. Consent is required to take such images. Additionally, patients may consent to release these medical photographs/slides, and videotapes for a stated purpose such as for use in instructional, educational, or promotional materials.

These materials are very important to insure continued understanding of the treatments available to all patients. Please read carefully the information contained in both sections below, and provide your consent where applicable. **A signature in section 1 is required to receive your care at [name of practice], a signature in section 2, while encouraged, is optional.**

1. CONSENT TO TAKE PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize **[physician name]**, Medical Director of **[name of practice]**, and/or his associates or licensees to take pre-procedural, and post-procedural photographs, slides, and/or videotapes.

I consent to the use of these images for the purposes of pre-procedural planning and post-procedural evaluation by **[physician name]** and/or the staff of **[name of practice]**, and I understand that they shall be made a part of my medical record.

Patient Signature: _____ **Date:**_____

Parent or Guardian (if patient is under 18 years of age):_____

Witness: _____

2. CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize **[physician name]**, Medical Director of **[name of practice]**, and or his associates or licensees to use pre-procedural, procedural, and post-procedural photographs, slides, and/or videotapes for professional medical or promotional purposes as deemed appropriate by them including but not limited to display of these images on public or commercial television, electronic digital networks, scientific medical publications, lay publications, or during lectures to medical or lay groups for the purposes of informing the medical community or the general public about aesthetic or

medical treatment procedures available at **[name of practice]**. Neither I nor any member of my family will be identified by name at any time. Unless it is necessary to include it, my face will not appear in the images. I understand that in some instances the images may portray features which could make my identity recognizable.
I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and I hereby grant this consent as a voluntary contribution in the interest of medical education. This permission may be rescinded by me at any time to prohibit future use by direct written communication with **[physician name] or [name of practice]**.

Patient Signature: _____ **Date:**_____

Parent or Guardian (if patient is under 18 years of age):

_____

Witness: _____