Photograph Use
Patient Consent Form

Patient Name: _____ Date: _____

Please read each paragraph and initial that you have read and understand the information.

Explanation

This consent form authorizes Dr. Landa Med Spa to use photographs (from a digital camera) for patient education, teaching, website and before and after photo books in office for patient viewing or used for promotion and marketing on social media. Your refusal to consent to the use of these photographs will in no way influence your treatment.

Consent

_____ I understand that photographs taken of me shall be used for medical records and if, in the judgement of the Dr Landa Med Spa staff, medical research, science or patient education may be benefited by the use of these photographs, I grant release and hold harmless the clinic, staff and consultants from any liability in the connection with the use of such materials.

_____ I waive the right that I may have any claims or royalties in connection with any exhibition, televising or publication of these photographs.

_____ I understand that the foregoing consent in subject to the following limitation: publication, film production, video tape or material exhibited will, in under no circumstances, contain my name unless voluntarily disclosed by me.

Patient Signature: _____ Date: _____

Dr. Signature: _____