

**Aesthetica
Cosmetic and Laser Surgery Center
1342 Chelsea Ave., Rear
Bethlehem, Pa. 18018
Phone: 610-861-9469**

PHOTO CONSENT AND RELEASE FORM

Patient Name: _____

Date: _____

I consent for photographs and/or video images to be taken of me by Aesthetica Cosmetic & Laser Center or a representative. I understand the images will be a part of my medical record and **refusal for images to be taken will limit the ability for any treatments**. I understand the images may be used for purposes of medical teaching or training or for marketing purposes (website, print, digital or social media).

By consenting to photographs and/or video images I understand I will not be compensated from any party. Although photographs and/or video images will be used without identifying information such as name, I understand it is possible someone may recognize me.

I further acknowledge that my participation is voluntary and agree that use of any photographs and/or video images confers no rights of ownership or royalties whatsoever.

I authorize the use of photographs and/or video images: (please initial indicating YES or NO below)

_____YES _____NO

For educational purposes (medical teaching or training),

_____YES _____NO

For marketing and advertising purposes (website, print, digital, or social media),

☐ Full Face

☐ Half Face

_____YES _____NO

At my request, my photographs and/or video images will only be used as part of my medical record.

I hereby release Aesthetica Cosmetic & Laser Center, its employees, and any third parties involved in the creation of or publication of educational or marketing materials, from liability for any claims by me or any third party in connection with my participation.

By signing this form, I confirm understanding of this consent. If I wish to withdraw my consent in the future, I may do so via written request submitted to Sheila Hayes, Business Manager or by completion of a new form.

Patient Signature: _____

Date: _____