Aesthetic Photo & Video Release

Authorization for before/after photography and use in marketing materials

Client Information

First Name *

Last Name *

Email Address *

Phone Number *

Date of Birth *

MM / DD / YYYY

Photo & Video Authorization

This authorization permits the practice to take photographs and/or video recordings of you before, during, and after your treatment(s). These images may be used for the purposes selected below.

I authorize use of my photos/videos for the following purposes: *

- [ ] Medical record documentation only
- [ ] Before & after portfolio (shown in-office to prospective patients)
- [ ] Practice website and social media accounts
- [ ] Paid advertising and promotional materials
- [ ] Educational presentations and training
- [ ] Press, media, and publications

Photo Anonymity Preference *

- [ ] Full face may be shown
- [ ] Eyes must be obscured/blacked out
- [ ] No identifiable facial features shown

Terms & Conditions

Terms of this Release:

1. I understand that the photographs/videos will remain the property of the practice.
2. I waive any right to inspect or approve the finished images or the context in which they are used.
3. I understand that I will not receive financial compensation for the use of my images.
4. I may revoke this authorization at any time by submitting a written request, but revocation will not apply to images already published or distributed.
5. My name will not be associated with published images unless I provide separate written consent.
6. I release the practice, its staff, and any affiliated parties from any claims arising from the use of my photographs/videos as described above.

I have read and understand the terms and conditions of this photo and video release authorization.

I have read and agree to the terms above: _____

Consent & Signature

I voluntarily authorize the practice to photograph and/or record me and to use such images as described in this release. I have read this document in its entirety and understand its contents.

I confirm I have read and understood the above information and give my informed consent.

I have read and understand the above information: _____

_____ _____

Signature Date

_____

Print name

Date *

_____

MM / DD / YYYY