# Patient Photo Release Form

Patient's Name _____ Date of Birth _____
Last First Middle

I hereby acknowledge that I have been advised that the photographs taken will be taken of me or parts of my body before and after surgeries and procedures. The photographs will be taken by one of the members of the Azul Cosmetic Surgery and Medical Spa medical staff. I hereby give my consent for Azul Cosmetic Surgery and Medical Spa to use the photographs under one of the following circumstances.

**Please initial one of the following:**

_____ **Internet:** Photographs taken of me or parts of my body as well as brief descriptions regarding the medical services that I have received at Azul Cosmetic Surgery and Medical Spa can be used on the company's website in order to inform the public about plastic surgery and cosmetic procedures. Further, I release and discharge Azul Cosmetic Surgery and Medical Spa, any employees of Azul Cosmetic Surgery and Medical Spa, and all parties acting under the license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and descriptions regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of empowering people to make smart, confident, self-improvement decisions, and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

_____ **All Media:** Photographs taken of me or parts of my body as well as brief descriptions regarding the medical services that I have received at Azul Cosmetic Surgery and Medical Spa can be used in any print or broadcast media, including, but not necessarily limited to newspapers, pamphlets, educational films, internet, and television, in order to inform the public about plastic surgery and cosmetic procedures. Further, I release and discharge Azul Cosmetic Surgery and Medical Spa, any employees of Azul Cosmetic Surgery and Medical Spa, and tall parties acting under the license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and descriptions regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

_____ **Medical Care Only:** Photographs taken of me or parts of my body can be used solely for the purpose of my medical care with Azul Cosmetic Surgery and Medical Spa. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at Azul Cosmetic Surgery and Medical Spa.

By signing this form, I acknowledge my consent as initialed above, and I further recognize that this consent form will supersede any other photo consent forms with a date prior to the date below. This consent may be revoked at any time by written request or by completion of a new form.

_____
Signature (Patient or Parent/Guardian if Patient is under 18) Date