cooltech DEFINE

PATIENT PHOTOGRAPHY RELEASE FORM

Patient Name:

I, _____, authorize Cryomed Australia and staff representatives, to take photographs of my body for medical purposes to be used for my patient care, marketing, literature and/or case presentations.

I understand that:

» Photographs are taken to capture treatment outcomes for the Cooltech procedure.

» They may be used for print, visual or electronic media including but not limited to, scientific presentations, websites and for purposes of informing the medical profession or general public about the procedure. These uses may also include marketing on behalf of Cryomed Australia.

» The images taken of me may be published by Cryomed Australia and its agents.

» I will not be identified by name in any of the published materials.

» My face will not be shown in the photographs nor will they reveal my identity.

» I have the right to request to revoke this authorization in writing at any time through a written revocation to Cryomed Australia.

I hereby release Cryomed Australia and its agents from any and all claims and demands arising out of, or in conjunction with, the use of the photographs.

I certify that I have read this release carefully and fully understand its terms. If I have any questions I can contact Cryomed Australia at 1300 346 448.

If under 18, guardian or parent must sign.

Print Name: _____ Signature: _____ Date: _____

Witness: _____ Date: _____