PATIENT PHOTOGRAPHY RELEASE FORM

Patient Name:

I, _____, authorize _____ to take photographs of my face and/or 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 ULFIT 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 _____.

» The images taken of me may be published by _____.

» 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 _____.

I hereby release _____ 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 _____.

If under 18, guardian or parent must sign.

Print Name: _____ Signature: _____ Date: _____

Witness: _____ Date: _____