DEVENIR AESTHETICS
AUTHORIZATION FOR RELEASE AND USE OF PHOTOGRAPHS

PATIENT: _____ DATE OF BIRTH:_____

TREATMENT:_____

PROVIDER: _____

CONSENT AND RELEASE FOR USE OF PHOTOGRAPHS, DIGITAL IMAGES, AND/OR VIDEOTAPES
Photographs and digital images will be taken for treatment documentation as an essential aspect to my treatment plan at Devenir Aesthetics. The physicians and providers utilize the images to assess the best treatment protocol for the patient. Photographs become a part of the medical record in the patients chart and will be handled in accordance with HIPPA regulations. This authorization grants Devenir Aesthetics to use the photographs (BUT NOT THE PATIENT NAMES) in the ways indicated below:

YOUR IDENTITY/PERSONAL INFORMATION WILL NEVER BE REVEALED
Please initial the consent area below for each specified use:

Yes____ No____ For medical research, education, science seminars or journals.

Yes____ No____ For use during in-office patient consultation.

Yes____ No____ For use on Devenir Aesthetics website.

Yes____ No____ For use on social media, either by Devenir Aesthetics or your provider's professional account.

Yes____ No____ For external marketing providing information about the physician, practice or procedure

I fully understand and agree to this consent form. I grant this consent as a voluntary contribution in the interest of medical education in consideration of services performed and consultations conducted by the providers at Devenir Aesthetics. There have been no representations or inducements concerning this consent, except as set forth herein.

_____ _____
PRINT Patient Name Patient Signature

_____ _____
PRINT Responsible Party *if different than patient* Responsible Party Signature *if different than patient*

_____ _____
PRINT Physician/Provider Physician Signature/Provider Signature