Photography Release Form

Patients First Name *

Patients Last Name *

Patients Date of birth *

__/__/____

Mobile Number *

(___) ___-____

Address 1 *

Address 2

Optional

City *

State *

Please select

Zip Code *

_____

I grant the Doctor and his/her practice permission to take and use photographs and digital images of me for the purpose of: *

- [ ] Teaching (i.e. Educational materials)
- [ ] Marketing (i.e. Web site, brochures, etc.)
- [ ] Other

This request and authorization applies to photography or digital images taken on:

Date of image capture *

__/__/____

I understand that once my photograph(s) or digital image(s) have been released, the Doctor and his/her practice may no longer have control over them, and federal or state privacy laws may no longer protect the information that was released.

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already used my photograph(s) or digital image(s) prior to me canceling this authorization, which would not prohibit any release done prior to the date of cancelation.

To cancel this agreement, I must write a letter to the doctor or practice advising of my wish to cancel my authorization to release photograph(s) or digital image(s) taken of me by this practice. I (or my authorized representative) must sign and date the letter.

If this authorization has not been canceled, it will expire 30 days after the date signed.

Patients First Name *

Patients Last Name *

- [ ] I am signing on behalf of the patient

Signature *

Today's Date

01/31/2024