DERMATOLOGY EXPERTS

I authorize my physician 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 my medical 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 physician's practice. They may be released to appropriate cosmetic companies and may be used for print, visual or electronic media including but not limited to, scientific presentations, websites, general marketing, and for purposes of informing the medical profession or general public about the medical procedure on behalf of the company. The images taken of me may be published by the physician, medical journal, pharmaceutical company and their agents and representatives. I will not be identified by name in any of the published materials. I have the right to revoke this authorization in writing at any time through a written revocation to my physician and company. I hereby release my physician, journal, pharmaceutical company and their agents and representatives from any and all claims and demands arising out of, or in conjunction with, the use of the photographs. The revocation notice will not affect any actions taken before the receipt of this written notification. I certify that I have read this release carefully and fully understand its terms. If under 18, guardian or parent must sign.

I hereby certify that I have read the foregoing CONSENT and fully understand and the contents thereof. Patient or legal guardians please sign.

Patient_____Date_____

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