

## **Photography Consent Form/Release**

I consent for medical photographs to be taken of me by the staff or representatives of SkinMed Institute PLLC. I understand that the images will be placed in my medical record and may be used for evaluation by employees of SkinMed Institute PLLC. By consenting to these medical photographs, I understand that I will not receive payment from any party. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me.

I also give permission for transfer of these photographs via a non-encrypted email exclusively for the purposes of third-party diagnostics, treatment and continuing medical care (e.g. communication with my primary care physician).

Refusal to consent to photographs will in no way affect the medical care I will receive.

All patients receiving cosmetic treatments are required to have photos obtained as a part of their medical record.

If I wish to withdraw my consent in the future, I may do so with a written request.

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_