

Photography Release

Patient's First Name *

Patient's Last Name *

Patient's Date of Birth *

__/__/____

I grant the Doctor and their 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**
- [ ] **None of the above**

I understand that once my photograph(s) or digital image(s) have been released, the Doctor and their 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.

The authorization will not be canceled unless patient provides an authorized cancellation date.

Patient's First Name *

Patient's Last Name *

Signature *

Sign Above

Today's Date