



INFORMED CONSENT FOR PHOTO AND RELEASE FORM

This release is strictly designed to give permission to **Desert Medical Rejuvenation** to take all necessary photographs needed before and after any treatment/procedure that I receive in the office. I hereby acknowledge that I am allowing a staff member of **Desert Medical Rejuvenation** to take all necessary photographs of my treatment/procedure and/or treated areas to be used for the purpose of monitoring my progress in the office. I understand that any photographs that are taken will become a part of my chart for medical records. By signing this release form, I acknowledge my consent and further recognize that this consent form will include any other photographs that will be taken in the future for further treatments/procedures. I have read and understood this consent and release.

Patient Name _____

Patient Signature _____ Date _____

Witness Name _____

Witness Signature _____ Date _____

Translator Name _____

Translator Signature _____ Date _____

(OPTIONAL) PERMISSION

- I hereby grant permission to **Desert Medical Rejuvenation** and its employees the right to use the photographs and/or video images taken of me, for the purpose of publication or advertising, in any manner or in any medium.

Patient Name _____

Patient Signature _____ Date _____

Witness Name _____

Witness Signature _____ Date _____

Translator Name _____

Translator Signature _____ Date _____