

# REN Dermatology & LASER CENTER

## Photographic Consent Form

I **consent** to the taking of photographs and/or film and sound recordings of me or parts of my body and grant REN Dermatology and/or Dr. Jennifer Lee and/or their designee permission to publish, distribute, and otherwise use such materials in all its publications.

I understand and agree to transfer all rights I may have in and to these materials, and that they will become the property of REN Dermatology and/or Dr. Jennifer Lee and will not be returned.

I hereby irrevocably authorize REN Dermatology to edit, alter, copy, exhibit, publish or distribute these materials for purposes of publicizing REN Dermatology's services or programs or for any other lawful purpose including, but not limited to:

- \* Medical purposes related to a case
- \* Scientific purposes, including seminars, medical articles, or educational presentations
- \* Before-and-after photo album (digital or printed) for cosmetic patients to view in office
- \* Before-and-after photographs and/or digital images and video to be included in newsletter, email blasts, or promotional materials
- \* Before-and-after photographs and/or digital images and video to be included in our website, Facebook, Instagram, and/or other social media platforms.

I understand that the materials, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Any disclosure of information carries with it the potential for an unauthorized re-disclosure, and the information may not be protected by applicable federal and/or state confidentiality rules.

Additionally, I waive any right to royalties or other compensation arising from or related to the use of any materials and understand that the copyright to all materials is retained by REN Dermatology.

I hold REN Dermatology and their designees harmless from any liability related to use of these materials for the purposes outlined above.

I am **18 years of age** and am competent to contract in my own name. I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Patient Photographic Consent Form and fully understand its terms.

**Print Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

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 I **DO NOT** consent to the taking of photographs and/or film and sound recordings of me or parts of my body and grant REN Dermatology and/or Dr. Jennifer Lee and/or their designee permission to publish, distribute, and otherwise use such materials in all its publications.

**Print Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_