CONSENT FOR PHOTOGRAPHY

Patient Name:_____ **Date of Birth:**_____

I, as the patient identified above or the legal representative of such patient ("**Patient**"), consent to have photographs, videotapes, digital or audio recordings, and/or images of the Patient, and any other method to reproduce or edit such Patient's likeness or image now known or hereafter developed (collectively, "**Photography**"), taken by ALC Medspa and its staff. I understand that such Photography will be recorded to document and assist with the Patient's care and to assist with ALC Medspa's health care operations.

I understand the Photography will become part of the Patient's medical record and therefore protected, used and/or disclosed in accordance with ALC Medspa's Notice of Privacy Practices. I understand that ALC Medspa will own the Photography, and I will not receive any payment for such Photography, but that I will be allowed to access or view them or to obtain copies of them as part of the Patient's medical record.

*Photography may be used for print, visual or electronic media including but not limited to, scientific presentations, ALC Medspa's before and after gallery, and for purposes of informing the medical profession or the general public about procedures.

Accept: _____ Decline: _____
Signature Signature

I have read this consent in its entirety and agree to be bound by all of its terms and conditions as described above. I acknowledge and agree that I have been given the opportunity to ask any questions and had all my questions answered to my satisfaction.

_____ _____
Patient Signature (or Legal Representative) **Date**

_____
Legal Representative's Authority (if applicable)

_____ _____
Witness Signature (ALC Medspa) **Date**

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