AUTHORIZATION TO RELEASE PHOTOGRAPHY OR DIGITAL IMAGES

Patient Name_____
Last First MI Maiden or Other Name

Date of birth _____/_____/_____ Phone Number_____

Address_____ City_____ State_____ Zip_____

I grant Dr._____ and his/her 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: _____**

This request and authorization applies to photography or digital images taken on

_____
Date(s) of image capture

I understand that once my photograph(s) or digital image(s) have been released, Dr. _____ and his/her 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.

If this authorization has not been canceled, it will expire _____ days after the date signed.

_____ _____
Patient Signature/Legal representative Date

_____
Relationship of legal representative