Authorization to Release and Disclose Photographs

Patient Name:_____
Date of Birth:_____

PLEASE READ EACH SECTION CAREFULLY. YOU MAY REQUEST A COPY OF THIS FORM FOR YOUR OWN RECORDS.

I, as the patient identified above or the legal representative of such patient ("**Patient**"), have consented to the taking of photographs, videotapes, digital or audio recordings, and/or images of Patient, and any other method to reproduce or edit such Patient's likeness or image now known or hereafter developed (collectively, "**Photography**"), by ME AESTHETICS/ ME AESTHETIC LOUNGE and its staff (collectively "**Practice**") which will be part of my medical record. I also understand that the Photography that identify Patient can be released and/or used outside the Practice only upon written authorization from me.

The Practice desires to utilize the Photography for purposes of professional publications, training, education, or clinical evaluation as well as on social media, including posting on social media accounts, including, but not limited to the Practice's website and social media platforms ("**Social Media**") and including such use in the Practice's email marketing campaigns, both of which will result in the publication and distribution of protected health information to the general public. The Practice IS NOT receiving direct or indirect remuneration from a third party in connection with the use/disclosure of the protected health information described in this authorization.

I understand that the Photography will be used on the Practice's website, social media, and email marketing, in which I have agreed to participate as a patient of Practice. I further understand that the use of the Photography in social media and marketing may incidentally disclose additional protected health information related to my treatment, condition, procedure, or other protected health information associated with such use, and I authorize such disclosure. I also understand that the use of the Photography can be released and/or used outside the Practice only with my written authorization.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to practice's privacy officer. I understand that a revocation is not effective to the extent that Practice has relied on the use or disclosure of the protected health information. I understand that, except as otherwise provided in this authorization, the Practice may use or disclose my protected health information in accordance with Practice's Notice of Privacy Practices. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or other applicable laws or regulations.

I specifically agree that the Practice shall have the right to interview, consult with and examine me at such times as Practice may reasonably request before, during and after my procedure, and that the Practice shall have the right to use such interviews, consultations, or examinations on social media. I understand that such use may result in these interviews, consultations and examinations being disclosed in the public domain.

I understand the Practice does not condition treatment or payment on the signing of this form. I understand that I will not be entitled to any payment or other form of remuneration from the Practice as a result of any

use of Photography.

I understand that I may revoke or withdraw this permission at any time to prohibit future use of my information. To do so, I must send written notice to Practice's privacy officer. I understand that a revocation is not effective to the extent that Practice has relied on the use or disclosure of the protected health information. This authorization is valid until the earlier or the occurrence of the death of Patient; Patient reaching the age of majority; or permission is withdrawn.

I release and hold harmless the Practice, its officers, staff and employees from any and all claims or causes of action that I may have of any nature whatsoever, which may in any manner result from use of the Photography. I understand that Practice will not condition my treatment or payment on whether I provide authorization for the requested use.

Printed Patient Name **Date**	**Signature of Patient**
Practice Representative Name	**Signature of Practice Representative**