Authorization for Use or Disclosure of Client Photographic and/or Video Images

Please read each section below and initial on the line.

Authorization – Please Choose One:

_____ I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by Fine Arts Skin & Laser. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer by protected by HIPAA privacy regulations.

*****OR*****

_____ I authorize the use and disclosure of my photographic/video images, and/or testimonial for marketing purposes by Fine Arts Skin & Laser as long as my identity is kept anonymous. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer by protected by HIPAA privacy regulations.

Purpose

_____ The photographic/video images, and/or testimonial may be used on our website, print and social media and/or for advertising purposes.

Revocability

_____ I understand that I may revoke this authorization at any time, but such revocation must be in writing and delivered to Fine Arts Skin & Laser.

No Treatment Conditions

_____ I understand that Fine Arts Skin & Laser cannot condition treatment on whether or not I sign this authorization.

I have read the above and understand it. The doctor has answered all questions satisfactorily. I allow Fine Arts Skin & Laser to use my photos and videos for promotional purposes.

_____ _____ _____

Patient Name (printed) and signature Date Witness