

Photo/Video Consent

I understand that photographs will be taken periodically throughout my treatments to monitor progress and other factors. I hereby give my consent to Rebecca Fitzgerald, MD, Inc to use these photos and/or video in the following capacities (please check boxes):

Yes	No	DESCRIPTION
<input checked="" type="checkbox"/>	<input type="checkbox"/>	EDUCATIONAL (medical journals/textbooks; lectures; published articles; etc; to advance the field of aesthetic medicine)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	IN-OFFICE MARKETING (promotional material in the office; office DVD reel; office books; office signage; office brochures; newsletters; etc; to educate our patients about treatments)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	OUT OF OFFICE MARKETING (television segments; printed articles; any outside office marketing; etc; excluding on-line marketing; to educate the public about treatments)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	ON-LINE (website; social media pages; review websites; office e-newsletters; etc; to educate the public about treatments)

NO!

I hereby release Rebecca Fitzgerald, MD, Inc and her agents from any and all claims and demands arising out of, or in conjunction with, the use of the photographs/video. Rebecca Fitzgerald, MD need not approach me again for authorization of the use of these photographs or videos. I am of legal age. I have read the forgoing fully and understand its contents.

Sophia Olicano
 Print Full Name
[Signature]
 Patient Signature
11/14/2016
 Date Signed

Jackie Sgarun
 Witness Full Name
[Signature]
 Witness Signature
11/14/2016
 Date Signed