Ballert
Medical Aesthetics

Patient 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 Ballert Medical Aesthetics and its staff (collectively "**Practice**"). I understand that such Photography will be recorded to document and assist with the Patient's care and to assist with Practice's health care operations.

My photographs may be utilized by the Practice, and the American Academy of Facial Plastic and Reconstructive Surgery in the following manner, as long as my identity is not made known:

a. Medical records (patient chart)
b. Medical research, education, or science
c. In professional journals, professional videos, or medical books
d. Office literature, speaking engagements, or office videotapes (i.e. consultation booklet, procedural or general information video, instructional booklets.).
e. Public relation purposes: including use in newspaper, magazine and brochures and TV appearances for public interest and information.

[Please cross-off letters 'd' and 'e' if you do not consent to these. We respect your right to privacy and would not release your photographs unless you are aware and have consented to this].

The undersigned acknowledges that he/she relinquishes all right, title, and interest in these photographs, and/or videotapes, or any profit or gain directly or indirectly realized through the use of the photographs and/or videotapes.

I understand that the Photography or a portion of the Photography may become part of my medical record and therefore be protected, used and/or disclosed in accordance with Practice's Notice of Privacy Practices. I further understand that Practice will own the Photography and I will not receive any payment for such Photography, but that I will be allowed to access or view the Photography or to obtain copies of any portion of the Photography that becomes part of my medical record.

I have read this consent in its entirety and agree to be bound by all 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.

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