Authorization For Use Or Disclosure Of Patient Photographic and/or Video Images

Authorization: I authorize the use and disclosure of my name, photographic/video images and/or testimonial for marketing purposes by Rejuvenation Concierge, LLC. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPPA privacy regulations.

Purpose: The photographic/video images and or testimonial will be used for social medial and/or advertising. I understand that photographs need to be taken for documentation purposes related to the medical procedure. If I choose not to authorize use of these photographs, they still must be taken but will be stored in a HIPPA compliant fashion and not shared or used for marketing purposes.

Revocability: I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from the date signed.

No Treatment Conditions: I understand that the practice cannot condition treatment on whether or not I sign this authorization.

[ ] initial here Check here if you desire a copy of this form to retain for your personal records.
[ ] Check here if you desire the ability to review any pictures prior to posting for public view.

[ ] Patient Name: _____

Date: _____

Signature:
_____