Your Practice Legal Name

Patient Photo, Video & Marketing Authorization

Before-and-after images, recordings and testimonials

1. Patient identification

Full legal name _____ Date of birth _____

Treatment or capture date(s) _____

Treatment(s) and body area(s) _____

2. What the practice may use or disclose

I authorize the practice named above and its authorized staff to use or disclose only the material described here for the purposes and recipients I select below.

- ☐ Before-and-after photographs
- ☐ Video recordings
- ☐ Other digital images
- ☐ Written testimonial

Specific images, footage or testimonial covered _____

Appearance (choose and initial one)

☐ Identifiable · Initials _____ ☐ Crop or obscure · Initials _____

Identifiable material may show my face or distinguishing features. If I choose crop or obscure, the practice must hide my face and distinguishing features, such as tattoos and birthmarks, and leave out my name and voice. Cropped material may still be recognizable.

3. Optional uses and recipients

Clinical photographs used for my care are kept in my medical record. I can leave the optional choices below blank for clinical-record-only use. Check and initial each optional use you allow.

☐ Internal education and training · Initials _____

The practice may share the selected material with its own staff for training or peer review.

☐ Education at a named event · Initials _____

The practice may share the selected material with the attendees named below for education.

Event name and date _____ Audience or recipient group _____

☐ Public marketing and promotion · Initials _____

The practice may share the selected material with the general public, including the users of the channels checked below, to promote its services. Select at least one channel if you allow public marketing.

- ☐ Practice website and photo gallery
- ☐ Practice social media accounts
- ☐ Paid digital advertising
- ☐ Email newsletters and digital brochures
- ☐ In-office displays and printed materials

Specific platforms or additional channel limits _____

4. Marketing payment and incentives (practice completes if applicable)

Choose one for public marketing.

☐ The practice receives no third-party payment for this marketing.

☐ The practice receives third-party payment for this marketing.

Third party and nature of payment, if applicable _____

Patient payment, free or discounted services, or other incentives (or write None) _____

5. My rights and when permission ends

Voluntary choice. My decision to sign or decline this authorization will not affect my treatment, payment, health plan enrollment or eligibility for benefits.
Revocation. I can cancel my permission at any time by sending a written request to the contact below. Canceling does not undo actions the practice already took in reliance on this authorization.

Privacy contact name or title _____

Email or mailing address for written revocation _____

Redisclosure. People who receive the material may copy or share it again. At that point, federal HIPAA privacy protections may no longer apply to the material.
Expiration for optional uses (choose one and complete it)

☐ Expiration date _____

☐ Event related to me or the purpose of this authorization _____

6. Signatures and copy

I have read this authorization and had an opportunity to ask questions. The practice will provide me a copy of the signed authorization.

Patient signature _____ Date _____

Personal representative name (if signing for patient) _____

Representative's authority to act for the patient _____

Personal representative signature _____ Date _____

Practice witness / staff signature _____ Date _____

☐ Practice provided a copy of the signed form.

Template for review. Ask qualified legal counsel to adapt it to applicable privacy, publicity and advertising laws before use.