PATIENT CONSENT FORM
CONSENT FOR THE TAKING AND PUBLICATION OF PHOTOGRAPHS, VIDEOTAPE, AND/OR COMPUTER IMAGES

I hereby consent that photographs, videotape, and/or computer imaging may be taken of me or of parts of my body under the following conditions:

Pre-treatment and post-treatment photographs will be taken of my treatment for medical record purposes. The photographs will be taken by my physician or staff member of my physician. I understand that these photographs will be the property of the attending physician and Libelle Aesthetics and Weight Loss Center.

Such photographs and/or videotape shall be used only for medical records, teaching, publication, marketing, or scientific research by my physician and Libelle Aesthetics and Weight Loss Center, provided that in any such publication the use of my name and identity is kept confidential and protected. Such photographs may be edited at the discretion of my physician to protect my confidentiality or emphasize a treated area.

» I have had the opportunity to discuss this consent with my attending physician or a qualified staff member of Libelle Aesthetics and Weight Loss Center. I agree that all of my questions have been answered.

» I have read and fully understand this Photo/Video/Computer Imaging Consent and agree to all of its terms.

» I understand the photographs taken by my attending physician or any member of staff of Libelle Aesthetics and Weight Loss Center *and* are for my medical record only.

»I give consent to Libelle Aesthetics and Weight Loss Center to use my photographs for marketing purposes, teaching, publications, and/or research.

Signature:_____

Print Name:_____

Date:_____

(OR)
» I have **declined** having any photos taken by my attending physician or any member staff of Libelle Aesthetics and Weight Loss Center.

Signature:_____

Print Name:_____

Date:_____