PATIENT PHOTOGRAPHY RELEASE FORM FOR VOTIVA

It is necessary that the staff at Taguchi Women's Clinic, PLLC take pre- and post-treatment photographs of our patients in order to track their progress and view their treatment results.

This consent permits photography of me or parts of my body related to the procedure(s) that has been or will be performed. This consent authorizes Taguchi Women's Clinic, PLLC to take photographs for the documentation of my medical progress.

Please check one or more of the following boxes, and initial at the end of the paragraph.

☐Yes☐No **Medical Care Only:** (*Required*) Photographs taken of me or parts of my body can be used for the purpose of documenting my medical care. _____ (Initial)

☐Yes☐No **Educational Purpose:** Photographs taken of treatment area(s) can be used to educate others regarding treatments. I understand that, if I consent for photography related to the procedure(s) for educational purposes, then my photographs may be used for the in-office photo album anonymously and no other forms of marketing without further consent. _____ (Initial)

☐Yes☐No **Website:** Photographs taken of treatment area(s) can be used on the website in order to inform others about methods and results. _____ (Initial)

☐Yes☐No **Social Media:** Photographs taken of the treatment area(s) can be used on our Facebook, Instagram or other social media sites in order to inform others about methods and results. _____ (Initial)

I certify that I have read the above photography release form and fully understand its terms.

_____

Signature of Patient or Legal Guardian Date

_____

Patients Name or Legal Guardian Printed

_____

Witness Date