



## Photo Release Form

I authorize Dr. Christopher R. Hubbell and/or his staff to take and keep photographs of me before, during, and after any procedures I may or may not enter into while under Dr. Hubbell's care. I further agree that Dr. Hubbell and/or his staff may use the negatives or prints made from such photographs for such purposes and in such manner as he may deem appropriate. My name will not be used unless I specifically agree that it may be used. **I also understand that these photos may be used for purposes including, but not limited to, educating future patients and in possible publications and promotions and that such use may be accomplished in any manner Dr. Hubbell wishes, with the exception of the following: \_\_\_\_\_.**

I have entered into this agreement willingly and hereby waive any right to compensation for such uses as Dr. Hubbell may determine. I also state that I and my successors or assigns hereby hold Dr. Christopher Hubbell and his successors and assigns and his staff harmless from and against any claim for injury or compensation resulting from the activities authorized by this agreement. The term "photograph" or "photo" as used in this agreement shall mean motion picture or still photography in any format as well as, videotape, video disc, and any other mechanical, digital or electronic means of reproducing images.

My name may be used as a reference to be given out to future patients. **YES NO**

Print Name: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

EMAIL: \_\_\_\_\_

under 18 years of age? **YES NO**

Parent's signature if minor child: \_\_\_\_\_

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I hereby give Acadiana Dermatology/a Jeuné Medical Spa the unqualified right to take pictures of me for inclusion in any medical records. However, **I DO NOT GIVE** Acadiana Dermatology/a Jeuné Medical Spa the right to use these pictures in portfolio/website/training of any sort.

Print Name: \_\_\_\_\_

Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Photographer/ Videographer: \_\_\_\_\_