

# Photo Release Form

Dear Patient:

Acadiana Dermatology and a Jeuné Medical Spa would like your authorization to have Dr. Christopher R. Hubbell and/or his staff photograph and/or video you before, during and after any procedures you may enter into while under Dr. Hubbell's care. We would further like your authorization that Dr. Hubbell and/or his staff may use the negatives or prints, digital recordings and electronic recordings made from such photographs for such purposes and in such manner as he may deem appropriate. Your name will not be used unless you specifically agree that it may be used. We are asking to use these photos 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 (i.e. website, before and after books, magazines, advertisements, etc)

1) May we use your photographs in these manners?    **Yes**    **No**

**If yes, please sign stating you agree to the following statement:**

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, digital, and/or electronic images and any other mechanical, digital or electronic means of reproducing images.

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

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

***If no, please understand that your photographs will still be taken but only for the inclusion of them in your medical records, and the photos will not be used in any of the manners mentioned in the above paragraph.***

2) May we identify you by name in conjunction with utilizing photographs or video of you?    **Yes**    **No**

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