



PATIENT PHOTOGRAPHY RELEASE FORM

Patient Name: _____

I, _____, authorize [insert practice name], [insert physician name] and staff representatives, to take photographs of my body for medical purposes to be used for my patient care, marketing, literature and/or case presentations.

I understand that:

- » Photographs are taken to capture treatment outcomes for the CoolSculpting® procedure.
- » They may be used for print, visual, or electronic media including but not limited to, scientific presentations, websites, for purposes of informing the medical profession or general public about the procedure. These uses may also include marketing on behalf of [insert practice name].
- » The images taken of me may be published by [insert practice name] and its agents.
- » I will not be identified by name in any of the published materials.
- » My face will not be shown in the photographs nor will they reveal my identity.
- » I have the right to revoke this authorization in writing at any time through a written revocation to [insert practice name].

I hereby release [insert practice name], [insert physician name] and its agents from any and all claims and demands arising out of, or in conjunctions with, the use of the photographs.

I certify that I have read this release carefully and fully understand its terms. If I have any questions I can contact [insert practice name] at [insert contact number].

If under 18, guardian or parent must sign.

Print Name: _____

Date: _____

Signature: _____

Witness: _____

Disclaimer: In the U.S., non-invasive fat reduction is cleared only for the flank (love handle).

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