WEST
GEORGIA
DERMATOLOGY

Authorization for Release and Use of Photographs

PATIENT: _____ DOB: _____

TREATMENT(S): _____

PROVIDER: _____

Photographs (including digital images) will be taken for treatment documentation purposes. Photographs will become part of the medical record in the patient chart and will be handled in accordance with the Health Insurance Portability and Accounting Act of 1996 (HIPAA). In addition, the undersigned grants to the treating physician the on-going and unrestricted right to use the photographs (but not the patient name) in the ways indicated below.

Your name/identifying information will not be revealed. Please **initial** consent (yes)/non-consent (no) for each specified use:

Yes ____ No ____ For medical research, education, or science (including medical seminars or journal articles)?

Yes ____ No ____ For use during in-office patient consultations?

Yes ____ No ____ For use on West Georgia Dermatology website?

Yes ____ No ____ For social media use, either by West Georgia Dermatology or your provider's individual professional social media account?

Yes ____ No ____ For external marketing/public relations use (including referral websites and print/television media that provides information about the physician, practice, or specific procedure)?

I am at least 18 years of age and am competent to contract in my own name. I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above consent form and fully understand its terms.

_____ _____

Signature of Patient (or Person Authorized) Date