Patient Photography Consent & HIPAA Authorization

Authorization for the use and disclosure of clinical photographs and video ("before and after" images) under 45 CFR § 164.508

PRACTICE / PROVIDER NAME

PHONE

PRACTICE ADDRESS

EMAIL FOR PRIVACY REQUESTS

1. Patient information

PATIENT FULL NAME

PHONE / EMAIL

DATE OF BIRTH

TREATMENT(S) / PROCEDURE(S) PHOTOGRAPHED

2. Description of the information to be used or disclosed

I authorize the practice named above to create photographs, digital images, and/or video recordings of me before, during, and after treatment. These images may show my face and/or the following body area(s):

These images are protected health information (PHI). This authorization covers the images described above together with limited related details the practice may display alongside them (for example, the treatment performed and the time between photographs). It does not cover any other part of my medical record.

3. Who may use or disclose the images, and who may receive them

The practice named above, and its employees and contractors involved in the uses I select in Section 4, may use or disclose the images. Depending on the boxes I initial, recipients may include visitors to the practice's website, social media audiences, attendees of professional education events, and readers of print materials.

4. Purpose — what I am agreeing to

Initial each use you approve. Leave blank any use you decline. Each option is separate: you may agree to some and refuse others, and your care will not be affected by your choices.

- ☐ **Treatment and my medical record.** Images used only for my clinical care, treatment planning, and progress tracking, stored securely in my patient record. *Initials:* _____
- ☐ **Internal education and training.** Images shown to the practice's clinical staff for training and quality purposes, within the practice only. *Initials:* _____
- ☐ **Practice website — before and after gallery.** *Initials:* _____
- ☐ **Social media** (specify platforms): _____ *Initials:* _____
- ☐ **Printed marketing materials** (brochures, in-practice displays, advertisements). *Initials:* _____
- ☐ **Professional presentations and publications** (conferences, journals, teaching outside the practice). *Initials:* _____

Identity protection — choose one:

- ☐ My face and identifying features **may** be shown.
- ☐ My identifying features must be **concealed** (e.g., eyes masked, tattoos and birthmarks obscured).
- ☐ Only images that **do not show my face** or other identifying features may be used.

My name will never be published with the images, and image files will not contain my name or other identifiers in filenames or metadata.

5. Expiration

This authorization expires (choose one):

- ☐ On this date: _____
- ☐ Upon this event: _____
- ☐ Five (5) years from the date of my signature below.

6. My rights and required notices

Right to revoke. I may revoke this authorization at any time by sending a written, signed request to the practice at the address or email listed above. Revocation takes effect when the practice receives it. It will not apply to uses or disclosures the practice has already made in reliance on this authorization, and images already published in print or shared by third parties may be impossible to fully retrieve. The practice will remove revoked images from its own website and social media accounts promptly, and in any case within 30 days.

Treatment is not conditioned on signing. The practice will not refuse or change my treatment, payment terms, enrollment, or eligibility for benefits based on whether I sign this authorization or which uses I approve. Signing is entirely voluntary.

Redisclosure warning. Once images are disclosed under this authorization — in particular once published online — they may be copied, shared, or redisclosed by others and may no longer be protected by federal privacy law (HIPAA).

No compensation. I understand I will not receive payment, royalties, or other compensation for the use of my images, now or in the future.

- ☐ Exception — the practice will provide the following remuneration (describe): _____

Copy of this form. I will receive a signed copy of this authorization for my records.

7. Signature

I have read this form (or had it read to me), my questions have been answered, and I sign it freely.

PATIENT SIGNATURE _____ DATE _____

PATIENT PRINTED NAME _____

PERSONAL REPRESENTATIVE SIGNATURE (IF PATIENT IS A MINOR OR UNABLE TO SIGN) _____ DATE _____

REPRESENTATIVE PRINTED NAME _____ RELATIONSHIP / AUTHORITY TO ACT FOR PATIENT _____

FOR OFFICE USE ONLY

STAFF MEMBER WHO WITNESSED SIGNATURE _____ IMAGE REFERENCE / CHART NUMBER _____

COPY GIVEN TO PATIENT — DATE & INITIALS _____ REVOCATION RECEIVED (DATE, IF ANY) _____