DRMEDSPA PHOTOGRAPH
AND INFORMED CONSENT FORM

_____

Last Name First Name

I hereby consent to have DrMedSpa photograph me and to use such photos for monitoring my response to therapy, other documentation purposes and medical education. I understand that no identifiable photographs of me will be disclosed to third parties except as required by law, and that no photographs of me will be used for marketing purposes without my written authorization.

_____ _____ Client
Signature (or Responsible Guardian) Date

_____ _____ Witness Date

Tech Initials Date