WESTLAKE
DERMATOLOGY
& Cosmetic Surgery

Release to Take & Use Photograph

PATIENT: ____________________________________ DOB: ________________

TREATMENT(S): ____

Photographs will be taken for documentation purposes. Do you authorize Westlake Dermatology & Cosmetic Surgery to use these photos in the following ways:

Yes ☐ No ☐ For inclusion in your electronic patient records? _____ *(initial)*

Yes ☐ No ☐ For the purposes of teaching and/or research (your identity *will not* be revealed)? _____ *(initial)*

Yes ☐ No ☐ For internal marketing use in patient presentations or Westlake Dermatology website? (your identity *will not* be revealed)? _____ *(initial)*

Yes ☐ No ☐ For external marketing or public relations use in referral websites (such as realself.com), print or television media providing information about the physician, practice, or specific procedure? (your identity *will not* be revealed)? _____ *(initial)*

____ ______________________

Signature of Patient (or Person Authorized) Date

____ ______________________

Signature of Physician or Assistant Date