ALC MEDSPA

EST. 2004

CONSENT FOR PHOTOGRAPHY

Patient Name:_____ **Date of Birth:**_____

I, as the patient identified above or the legal representative of such patient ("**Patient**"), consent to have photographs, videotapes, digital or audio recordings, and/or images of the Patient, and any other method to reproduce or edit such Patient's likeness or image now known or hereafter developed (collectively, "**Photography**"), taken by ALC Medspa and its staff. I understand that such Photography will be recorded to document and assist with the Patient's care and to assist with ALC Medspa's health care operations.

I understand the Photography will become part of the Patient's medical record and therefore protected, used and/or disclosed in accordance with ALC Medspa's Notice of Privacy Practices. I understand that ALC Medspa will own the Photography, and I will not receive any payment for such Photography, but that I will be allowed to access or view them or to obtain copies of them as part of the Patient's medical record.

I have read this consent in its entirety and agree to be bound by all of its terms and conditions as described above. I acknowledge and agree that I have been given the opportunity to ask any questions and had all my questions answered to my satisfaction.

_____ _____

Patient Signature (or Legal Representative) **Date**

_____

Legal Representative's Authority (if applicable)

_____ _____

Witness Signature (ALC Medspa) **Date**

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