PHOTO RELEASE

I, ____ authorize Shea Aesthetic Clinic to take photographs of my face and body. These photos will be kept in a chart bearing my name and will be kept and used with the utmost respect. With the sole intent of encouragement to others that may be considering the same or similar procedure, your photos may be considered of such good quality that we choose them for an online photo gallery and/or on a social media platform to educate future patients. At no time will any personal information or name be given. These photographs may be used for patient referrals and/or educational purposes.

OR

I, ____ DO NOT authorize Shea Aesthetic Clinic to use any photography of my face and body online and/or on social media platforms. Any photography should only be used to educate myself and the providers at Shea Aesthetic Clinic on the progress of my healing and treatment plan.

Patient Signature ________________________________ Patient Name (Print) __________________________
Date ______________________________

Witness Signature________________________________ Witness (Print) _______________________________
Date ______________________________