Before-and-After Patient Photo Release Form

Patient Name:

Date of Birth:

Procedure(s) Performed:

- [ ] I authorize the use of my before-and-after photographs for the following purposes:
- [ ] Website
- [ ] Social Media
- [ ] Print Materials
- [ ] Educational/Training

- [ ] I understand that my identity will remain confidential and only my images will be used.
- [ ] I consent to my identity being revealed in association with my photographs.

Additional Comments or Restrictions:

Patient Signature:

Date:

Witness Signature:

Date: