Harmony Community Clinic
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Photography and Media Consent

Patient name (print) _____ Date of birth _____ Date _____

1. Clinical photographs (medical record)

Photographs and measurements taken before, during, and after treatment are an important part of my medical record for weight management and aesthetic procedures. These photos are kept confidential, stored securely, and used only for my care and treatment planning.

I consent to clinical photographs and measurements for my medical record. _____ Initials

2. Marketing and educational use (optional)

Harmony Community Clinic may wish to use my photos or videos on its website, social media (such as Instagram and Facebook), printed materials, or in professional education. Saying no will not affect my care in any way. Choose one:

☐ I DO NOT give permission for marketing or educational use.
☐ I give permission ONLY if my face and identifying features (tattoos, birthmarks, jewelry) are hidden or cropped.
☐ I give permission to use my photos or videos, including my face.

3. Terms

- My name will not be published with my images unless I give separate written permission.
- I will not receive payment or other compensation for the use of my images unless agreed in a separate written agreement.
- I may revoke permission for marketing use at any time in writing. The clinic will stop new uses, but cannot remove images that were already printed or shared by others.
- The clinic owns the photographs, which are part of my medical record.

I understand and agree to the choices I selected above. _____ Initials

Signatures

By signing below, I confirm that I have read this form (or had it read to me) in a language I understand, that I had the opportunity to ask questions and all of my questions were answered, and that I agree to its terms voluntarily.

Patient name (print) _____ Patient signature _____ Date _____

Parent / guardian / legal representative (print, if applicable) _____ Relationship to patient _____ Representative signature _____ Date _____

Provider name and credentials _____ Provider signature _____ Date _____

Tell us about your visit

Your opinion helps other families find quality care. After your visit, scan this code with your phone camera to leave Harmony Community Clinic a review on Google.

Thank you for trusting us with your health.