PHOTO/VIDEO RELEASE FORM

Patient Photo and Video Release Form Template
[NAME OF HEALTHCARE PRACTICE/ORGANIZATION]
PHOTO AND VIDEO CONSENT AND RELEASE FORM

I. Parties Involved

- **Patient/Releasor:**
  - Printed Name: _____
  - Date of Birth: _____
  - Address: _____
  - Phone: _____ Email: _____
- **Healthcare Practice/Releasee:**
  - Name: [Name of Practice/Organization]
  - Address: [Address]

II. Consent and Scope of Release

I, the Patient named above (or legal guardian if the patient is a minor), hereby grant and authorize the Healthcare Practice, and its agents, assignees, and clients ("Grantees"), the irrevocable right to capture, use, edit, alter, copy, exhibit, publish, distribute, and make use of my image, likeness, voice, and/or Protected Health Information (PHI) as described below.

- **Media Types Covered (initial all that apply):**
  - _____ Still photographs
  - _____ Video recordings
  - _____ Audio recordings
  - _____ Quotes/written testimonials
  - _____ My Protected Health Information (PHI), which may include before/after images, treatment details, etc.
- **Purpose and Use (initial all intended uses):** I authorize the use of the media for:
  - _____ Educational purposes (e.g., medical teaching, training, research presentations)

- _____ Marketing and advertising (e.g., website, social media, print materials, email marketing, brochures)
- _____ Internal medical records only (images used solely within my confidential medical chart)

- **Platforms (where the media may appear):**
  The media may be used by the practice and its affiliates in any format and on any platform, including websites, social media, digital ads, print materials, educational or internal use, and any other current or future media.

III. Terms and Waivers

By signing this form, I confirm my voluntary participation and understand that no compensation will be provided for the use of the media. I waive the right to approve the final product and release the Healthcare Practice and its agents from liability for claims such as invasion of privacy or defamation. I also acknowledge that my healthcare will not be affected by my decision to sign or not sign this release and that I can revoke this authorization in writing, though not for media already in use.

IV. Patient/Guardian Signature

I am over 18 and understand the terms of this release.

Signature of Patient or Legal Guardian

Date

If the patient is a minor, a parent or legal guardian must complete the following section.
I am the parent or legal guardian and have the authority to sign for the minor. I am over 18.

Signature of Parent/Legal Guardian

Date