Photograph Consent & Release
Pink Ink

I, **(PLEASE PRINT NAME)** ______________________________________, as a patient of Pink Ink, consent to photographing of myself. I understand that these photographs will become a part of my medical record and are the property of Pink Ink. I understand that these photographs will NOT be shown to other patients, nor will they be used in publications, unless I consent to that below.

I understand that if I do consent to any of the following uses of my photographs, that my name will not be used in conjunction with it.

YES	NO	N/A*	Proposed Use
			Use of Before and After photos of my body to show other patients
			Use of Before and After photos of my body for publications**
			Use of Before and After photos of my face to show other patients
			Use of Before and After photos of my face for publications**

*N/A = not applicable
**Publications may include newsletters, published articles, books, internet or other published media.

This consent remains in effect until otherwise notified in writing.

______________________________________ ______________
Patient Signature Date

______________________________________ ______________
Witness Date

Last Revised 1/20/10