Lakes COSMETIC INSTITUTE

Photography Release Form

Date: _____ Patient #: _____

Name (please print): _____

I hereby give permission for my photograph to be taken by Dr. King or Lakes Cosmetic Institute staff to be used to evaluate my skin thoroughly, keep sequential records and to allow the doctor and staff to communicate with me more completely.

Signature: _____

Furthermore, if checked below, I give permission for my photos and /or testimonial to be used for the following purposes:

___ Newspaper

___ Magazines

___ LCI Website

___ Posters/Rack Cards

___ Videos

___ Commercials/TV

___ Internet/intranet

___ Social Media (Facebook Twitter, YouTube)

The materials will not contain my name or any other personal identifying information, but may contain images that would give away my identity.

I have the opportunity, at my request, to review any materials that will be used and unless I notify all authorized parties in writing that the materials are not to be used for these purposes prior to their release, the authorized parties may make such indicated uses. I will contact the Director of Public Relations and Volunteer Services (603) 528-2895 or 80 Highland Street, Laconia, NH 03246 if I wish to withdraw my permission.

I have considered this decision carefully and I understand my decision is voluntary and that I am not required to grant the permission described herein.

Signature: _____