PATIENT PHOTOGRAPHY RELEASE FORM

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Cheeky medspa L.L.C., Randi Hall, RN and staff representatives, to take photographs of my body for medical purposes to be used for my patient care, marketing, literature and/or case presentations.

I understand that:

* They may be used for print, visual or electronic media including but not limited to, scientific presentations, websites and for purposes of informing the medical profession or general public about the procedure. These uses may also include marketing on behalf of Cheeky Medspa L.L.C.
* The images taken of me may be published by Cheeky Medspa L.L.C. and its agents.
* I will not be identified by name in any of the published materials.
* I have the right to revoke this authorization in writing at any time through a written revocation to Cheeky Medspa L.L.C.

I hereby release Cheeky Medspa L.L.C., Randi Hall, RN and its agents from any and all claims and demands arising out of, or in conjunction with, the use of the photographs.

I certify that I have read this release carefully and fully understand its terms. If I have any questions I can contact Randi Hall, RN at 907-252-2419.

If under 18, guardian or parent must sign.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_