



Patient Consent for Photography

I, as the patient identified above or the legal representative of such patient (“**Patient**”), consent to have photographs, videotapes, digital or audio recordings, and/or images of the Patient, and any other method to reproduce or edit such Patient’s likeness or image now known or hereafter developed (collectively, “**Photography**”), taken by (Face of the Valley Aesthetics, LLC) and its staff (collectively “**Practice**”). I understand that such Photography will be recorded to document and assist with the Patient’s care and to assist with Practice’s health care operations.

I understand that the Photography or a portion of the Photography may become part of my medical record and therefore be protected, used and/or disclosed in accordance with Practice’s Notice of Privacy Practices. I further understand that Practice will own the Photography and I will not receive any payment for such Photography, but that I will be allowed to access or view the Photography or to obtain copies of any portion of the Photography that becomes part of my medical record.

I have read this consent in its entirety and agree to be bound by all its terms and conditions as described above. I acknowledge and agree that I have been given the opportunity to ask any questions and had all my questions answered to my satisfaction.

Printed Patient Name

Date

Signature of Patient

Giacinta Roupas, CRNA, Owner

Practice Representative Name

Giacinta Roupas, CRNA

Signature of Practice Representative