

## Patient Release of Photographs

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

Patient Address: \_\_\_\_\_  
\_\_\_\_\_

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

I being the undersigned, a patient of Mark Grimsley, MD consent to be photographed and/or visually recorded before, during and after laser or IPL treatments with the understanding that these visual recordings, still images and adaptations may be used for professional and patient education purposes as well as physician workshops and seminars, and in certain medical and marketing materials.

The undersigned grants Mark Grimsley, MD the ongoing and unrestricted right to the use of these images and acknowledges that he/she relinquishes all rights, title and interest in these materials.

This information and the effect of my consent have been fully explained to me and any questions I had are fully answered.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness Signature \_\_\_\_\_

Date \_\_\_\_\_