Kingwood DermSpa
19701 Kingwood Drive Bldg. 6
Kingwood, Texas 77339

PATIENT CONSENT FORM

Consent for the taking and publication of photographs; video; and/or computer images.

I, (Printed Name) _____, hereby consent that photographs; video; and/or computer imaging may be taken of me or of parts of my body under the following conditions:

_____ Pre-treatment and post-treatment photographs will be taken of my treatment for medical record purposes. The photographs will be taken by my provider or staff member of my provider. I understand that these photographs will be the property of DermSurgery Associates/Kingwood DermSpa.

_____ Pre-treatment and post-treatment photographs will be taken of my treatment for medical record purposes. Such photographs and/or video shall be used only for medical records; teaching; publication; marketing; or scientific research by my provider and DermSurgery Associates/Kingwood DermSpa.

_____ I have had the opportunity to discuss this consent with my attending provider or qualified staff member of DermSurgery Associates/Kingwood DermSpa. I agree that all of my questions have been answered. I hereby waive all rights I might have to such photographs; video; and computer images and do hereby release, discharge, and save harmless my provider or physician and DermSurgery Associates/Kingwood DermSpa as well as their respective managers & employees from all such claims and liabilities whatsoever in law and in equity arising from the use of such photographs; video and computer images described above.

_____ I have ***declined*** having any photos taken by my provider; attending physician or any staff member of DermSurgery Associates/Kingwood DermSpa.

I have read and fully understand this Photo/Video/Computer Imaging Consent and agree to all of its terms.

Patient Signature: _____, Date: _____

Witness Signature: _____, Date: _____