SPARKLE HEALTH

AESTHETICS & WELLNESS

MEDICAL PHOTOGRAPHY CONSENT & RELEASE

Patient legal name

Date of birth

PURPOSE OF PHOTOGRAPHS

Sparkle Health Aesthetics & Wellness requests permission to take before-and-after photographs of the treatment area(s) to document baseline appearance, evaluate treatment progress and results, and maintain clinical records.

CLINICAL PHOTOGRAPHY PERMISSION

☐ YES - I authorize clinical before-and-after photographs.

☐ NO - I do not authorize clinical photographs.

I understand that declining photography may limit visual comparison of treatment results, but will not by itself prevent me from requesting care. If I agree, photographs will be handled as part of my confidential clinical information and accessed only for appropriate healthcare purposes, subject to applicable law.

NO PROMOTIONAL OR MARKETING USE WITHOUT PERMISSION

I will not use your picture on my website or any other promotional or marketing items without your knowledge or permission.

Clinical photography consent does not grant permission to post, publish, advertise, share on social media, or otherwise use photographs for promotional purposes. Any such use requires a separate written authorization describing the proposed use and disclosure.

PATIENT RIGHTS AND LIMITATIONS

You may ask questions before photographs are taken. You may withdraw permission for future clinical photography by notifying Sparkle Health. Withdrawal does not undo photographs already taken or lawful uses already made. Photos retained as part of the medical record may be subject to applicable record-retention requirements.

ACKNOWLEDGMENT

I have read this form, understand the purpose and limits of clinical photography, and have had an opportunity to ask questions. I understand this is not an authorization for advertising or marketing.

Patient / authorized representative signature (type full name)

Date

If signed by representative, name and relationship / authority