Patient Media Release Form

Patient Information:

Patient's Name ________________________________ Patient's Date of Birth ________________

I hereby authorize **Ideal Body Inc** (the "Company") to use and disclose photographs, videos or illustrations (the Media) and all aesthetic treatment-related information, taken or collected by my health care provider (the "HCP") in conjunction with my aesthetic treatment(s) on or about _______________, 20_____, all of which include information considered "protected health information" ("PHI") under the Federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

I authorize the Company, in its sole discretion, to use and disclose the Media and aesthetic Information on its corporate and product websites, in printed brochures, news releases, videos, television and other media marketing materials for any bona fide business purpose, including, but not limited to, dissemination to employees, clients, health professionals and members of the general public for educational, research, scientific, public relations, marketing, or advertising in any form of media, and that such dissemination may be accomplished in any manner deemed appropriate by the Company. Such purposes may include showing actual patient results through the use of "before" and "after" photographs. I understand that once so used and disclosed, the Company has no control or responsibility over how my Photos will be used or further disclosed. Neither I, nor any member of my family, will be identified by name in connection with the Photos or aesthetic Information at any time. If I have any questions regarding this Authorization, I should call **Ideal Body Inc** at 516-266-6363. I understand that I have the right to revoke this Authorization at any time, and in order to do so, I must send written notification to *Ideal Body Med Spa, 400 Post Ave, Suite LL1, Westbury, NY, 11590*.

Please initial ONE of the following options:

______ Yes, (photos of **Face and Body**) I agree to the terms of the Authorization above.

______ Yes, (photos of **Body only**) I agree to the terms of the Authorization above.

______ No, I authorize my photographs to be used **only** for my medical record, my treatment record and insurance purposes of my treatment with Ideal Body Inc. I understand these photos will not be used on the office website or in any publications.

Signature: ____ Date: _________________________

Print Name: ____

A COPY OF THIS SIGNED AUTHORIZATION MUST BE PROVIDED TO THE PATIENT