OHIO SKIN CENTER

DERMATOLOGY • SURGERY • COSMETICS

PATIENT MEDIA RELEASE CONSENT

I hereby authorize Ohio Skin Center, to capture and publish photographs and videos for the potential use and distribution on any online platforms and social media accounts not limited to: Facebook, Instagram, Google, and ohioskin.com for digital advertising. I understand that the information may also be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journals.

By consenting to these medical photographs and videos, I understand that I will not receive payment from any party. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. Refusal to consent to photographs will in no way affect the medical care I will receive. If I wish to withdraw my consent in the future, I may do so with a written request.

I authorize the use of this media for the follow:

	YES	NO
For medical purposes and in the office us only (Pre/Post procedures or Pre/Post Cosmetics)		
On our website for prospective patients, social media platforms, or the internet		
In print/advertisements, professional journals, educational purposes, or presentations		

By signing below, I confirm that this consent form has been explained to me in terms which I understand.

- ❑ I do not give my consent for Ohio Skin Center to capture and release any media of myself.
- ❑ I do give my consent for Ohio Skin Center to capture and release any media of myself.

_____ _____

Patient Name (Print) Ohio Skin Center

_____ _____

Patient Signature Date

_____

Date

- ❑ Please check this box if you are the legal guardian filling this out on behalf of the patient.