GENERATIONS
MEDICAL AESTHETICS
SKIN & LASER CENTER

Medical Photography Authorization

I authorize Generations Medical Aesthetics to use my pre-treatment and post-treatment photographs for clinical assessment, patient instruction and educational purposes only.

I understand that photographs will always remain the property of Generations Medical Aesthetics, but I may receive a copy of my before and after photographs.

I hereby authorize Generations Medical Aesthetics to use and disclose my individually identifiable Protected Health Information ("PHI") in the manner described above. I understand that my health care will not be affected if I do not sign this form. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____
Patient Name (please print)

_____ _____
Patient Signature or Legal Representative Date

_____
Relationship to Patient (if not self)

OFFICE USE ONLY

I attempted to obtain the patient's signature authorizing the use of their pre-treatment and post-treatment photographs for clinical assessment, patient instruction and educational purposes only. I was unable to do so as documented below:

Date:	Initials:	Reason: