PATIENT PHOTOGRAPHY RELEASE FORM

Patient Name:

I, (type name)_____, authorize Bodify and staff representatives, to take photographs of my body for medical purposes to be used for my patient care, marketing, literature and/or case presentations.

I understand that:

» Photographs are taken to capture treatment outcomes for the CoolSculpting® procedure.

» They may be used for print, visual or electronic media including but not limited to, scientific presentations, websites and for purposes of informing the medical profession or general public about the procedure. These uses may also include marketing on behalf of [insert practice name].

» The images taken of me may be published by [insert practice name] and its agents.

» I will not be identified by name in any of the published materials.

» My face will not be shown in the photographs nor will they reveal my identity.

» I have the right to revoke this authorization in writing at any time through a written revocation to [insert practice name].

I hereby release [insert practice name], [insert physician name] and its agents from any and all claims and demands arising out of, or in conjunction with, the use of the photographs.

I certify that I have read this release carefully and fully understand its terms. If I have any questions I can contact Bodify at (602) 354-8040.

If under 18, guardian or parent must sign.

Name: _____ Initials: _____ Date: _____

Witness: _____Initials_____ Date: _____

By checking here_____, I understand that by typing in my name and initials above, this serves as my written name and signature respectively.