DESERT MEDICAL REJUVENATION
REGAIN YOUR YOUTHFUL APPEARANCE

ART QUINTANILLA MD
BOARD CERTIFIED PHYSICIAN

INFORMED CONSENT FOR PHOTO AND RELEASE FORM

This release is strictly designed to give permission to Desert Medical Rejuvenation to take all necessary photographs needed before and after any treatment/procedure that I receive in the office. I hereby acknowledge that I am allowing a staff member of Desert Medical Rejuvenation to take all necessary photographs of my treatment/procedure and/or treated areas to be used for the purpose of monitoring my progress in the office. I understand that any photographs that are taken will become a part of my chart for medical records. By signing this release form, I acknowledge my consent and further recognize that this consent form will include any other photographs that will be taken in the future for further treatments/procedures. I have read and understood this consent and release.

Patient Name_____

Patient Signature_____ Date_____

Witness Name_____

Witness Signature_____ Date_____

Translator Name_____

Translator Signature_____ Date_____

(Optional)

☐ I hereby grant permission to Desert Medical Rejuvenation and its employees the right to use the photographs and/or video images taken of me, for the purpose of publication or advertising, in any manner or in any medium.

Patient Name_____

Patient Signature_____ Date_____

Witness Name_____

Witness Signature_____ Date_____

Translator Name_____

Translator Signature_____ Date_____

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