Digital Images for Social Media Consent Form

Patient Name _____

Date of Birth _____

Parent/Legal Guardian Name (if under 18) _____

☐ I confirm that I am the patient or the patient's legal parent/guardian and have the power to give this authorization.

Practice/Facility Name_____

Authorization for Photography and Use

I approve _____ and its representatives to photograph and/or record video or audio of me (or the patient named above). Videos may include a recording of my voice.

I approve the use and disclosure of these images for these purposes (check all that apply):

☐ Practice website

☐ Social media (e.g., Facebook, Instagram)

☐ Marketing or promotional materials

☐ Educational materials

☐ Internal use only (not publicly shared)

Use Preferences (Optional)

Please select your level of consent:

☐ Full use, including social media

☐ Use without identifying information (no name or personal details)

☐ Internal use only (no public or social media use)

Additional restrictions (if any): _____

Use and Disclosure Information

I understand that:

- The practice will make reasonable efforts to de-identify images when possible and only use the minimum needed.
- My name, voice, or identifying information will not be used without my permission.
- Once images are posted on social media or public platforms, they may be viewed, copied, or shared by others outside the control of the practice.

Voluntary Authorization and Acknowledgment

I confirm that:

- I am the patient or the patient's parent/legal guardian and have authority to give this authorization.
- My decision to approve or decline will not change the patient's care.
- I have had the chance to ask questions. All questions have been answered to my satisfaction.

No Compensation

I understand that I will not be paid or otherwise compensated for the use of these images or recordings.

Right to Revoke

I understand that I may cancel this authorization in writing at any time. I understand this cancellation will not apply to images or information that have already been used or disclosed based on this authorization.

Consent

By signing below, I agree to the use of pictures/digital images and/or videos as described in this form.

_____ _____
Signature of Patient or Responsible Party Date and Time

_____
Printed Name

_____
Relationship to Patient (if Responsible Party is not Patient)

_____ _____
Witness Date and Time

Internal Documentation (Practice Use Only)

Consent Reviewed Prior to Photography: ☐ Yes ☐ No Staff Initials _____
Type of Images Taken: ☐ Photo ☐ Video ☐ Both Date Images Obtained _____
Approved Use Category: ☐ Internal Use Only ☐ Marketing / Social Media ☐ Educational
Restrictions Documented _____
Storage Location _____