AOB
ALL OVER BEAUTIFUL
MED SPA

PHOTOGRAPH
AND INFORMED CONSENT FORM

_____

Last Name **First Name**

I hereby consent to have AOB Med Spa photograph me and to use such photos for monitoring my response to therapy, other documentation purposes and medical education. I understand that no identifiable photographs of me will be disclosed to third parties except as required by law, and that no photographs of me will be used for marketing purposes without my written authorization.

_____ _____
Client Signature (or Responsible Guardian) Date

_____ _____
Witness Date

_____ _____
Tech Initials Date