INFORMED CONSENT FOR MEDICAL PHOTOGRAPHY

I hereby authorize Desiree Merulli, L.Ac., EAMP, RYT, as well as any associates she may designate, to take photographs of me (including digital images) for diagnostic and treatment purposes and to enhance medical records.

I agree that these images will remain the property of Merulli Acupuncture & Wellness and that I may request a copy of these images if needed.

I understand that these photos are vital for diagnosis and treatment planning, and may be utilized for lectures, continuing medical education and scientific papers. **_____ (please initial)**

I consent to my photographs being utilized for patient education, including patient information brochures, as well as “Before and After” displays in our office.

☐ I DO
☐ I DO NOT

I consent to my photographs being utilized for “Before and After” displays on our website and social media pages. I understand that additional consent will be asked of me after the procedure is completed.

☐ I DO
☐ I DO NOT

_____

Name Signature of Patient Date

Merulli Acupuncture & Wellness

509 OLIVE WAY, # 1658 SEATTLE, WA 98101