

PHOTO CONSENT AND RELEASE FORM

I, the undersigned, do hereby agree to the following. I am allowing Medical Laser Solutions or a staff member to take photos of my treatment and/or treated areas to be used for the purpose of monitoring my progress, education and/or advertising.

At my request, my identity will remain anonymous. _____ (please initial).

Print Name: _____

Signature: _____ Date: _____

Witness: _____ Date: _____