ANODYNE
PAIN & WELLNESS SOLUTIONS
OF CENTRAL OHIO

PHOTO CONSENT AND RELEASE FORM

Patient Name: _____

I consent for photographs and/or video images to be taken of me by Anodyne Pain & Wellness Solutions of Central Ohio or a representative. These images or clips may be shared with staff, other physicians or healthcare professionals, and members of the public for educational or marketing purposes.

By consenting to photographs and/or video images I understand I will not be compensated from any party. I acknowledge that my participation is voluntary and agree that use of any photographs and/or video images confers no rights of ownership or royalties whatsoever.

Please initial next to <u>JUST ONE</u> of the following options regarding the authorized use of photographs and/or video images:

_____ **I OPT OUT**. I do not want my photographs to be used for advertising or marketing. They may only be used as part of my medical chart.
_____ **EDUCATIONAL PURPOSES ONLY**. Photographs taken of me or parts of my body as well as details regarding services that I have received may be used for scientific presentations and/or publications.
_____ **ALL MEDIA EXCLUDING SOCIAL MEDIA**. Photographs taken of me or parts of my body as well as details regarding services that I have received may be used in any print or broadcast media, including but not necessarily limited to newspapers, pamphlets, educational films, practice website, and television, to inform or educate the public or other physicians.
_____ **ALL MEDIA INCLUDING SOCIAL MEDIA**. Photographs taken of me or parts of my body as well as details regarding services that I have received may be used in any form of media traditional, digital, or social.
_____ **PRACTICE WEBSITE ONLY**. Photographs taken of me or parts of my body as well as details regarding services that I have received may be used on the Anodyne website without disclosure of personal information. The exception to this rule is for testimonials, in which only your first name will be shared.

Please review and initial each of the following:

_____ **REVOCATION**. I understand that I may revoke this authorization at any time; however, such revocation must be in writing and received via registered mail. Revocation affects disclosure moving forward and is not retroactive.
_____ **EXPIRATION**. This authorization expires 99 years from the date signed.
_____ **VOLUNTARY CONSENT**. I understand that my participation is voluntary. If I do not sign this form, my healthcare and payment for my healthcare will not be affected.
_____ I will not receive compensation for my participation.
_____ By signing this form, the personal healthcare information I relay or allow to be related to an outside source, such as a social media platform or news source, is no longer protected by state and federal privacy laws and may be re-disclosed by that source.

Date: _____ Witness: _____

Patient Name: _____

Patient or Guardian Signature: _____