**Consent Form for Use of Photographs or video recordings**

**Participant Information**

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| Phone Number |  |
| Email |  |

**Consent for Use of Photographs or video recordings**

I, the undersigned, hereby grant [Doctor’s/Practitioners Name &/or Clinic Name] permission to use my name / photograph(s) or videos(s) for the purpose of publicising and promoting the [Doctor’s/Practitioners Name &/or Clinic Name] services and activities.

**Scope of Consent**

I understand that the photographs may be used in various formats, including but not limited to:

* Printed materials (brochures, posters, flyers)
* Online media (website, social media platforms)
* Presentations and promotional events
* Advertising and marketing campaigns

I also acknowledge that I understand that I may not be able to stop the subsequent use of photos or video recordings once I have agreed for it to be broadcast.

**Duration of Consent**

This consent is given in perpetuity unless I revoke it in writing. I acknowledge that I will not receive any compensation for the use of the photographs.

**Revocation of Consent**

I understand that I have the right to revoke this consent at any time by providing written notice to [Clinic Name]. Upon receipt of such notice, the clinic will cease any future use of my photograph(s) or video(s) in new materials.

**Declaration**

I declare that I am of legal age and have the full right and authority to grant this consent. I have read and understood the above information and agree to the terms stated.

|  |  |
| --- | --- |
| Signature |  |
| Date |  |
| Witness Signature |  |
| Date |  |
|  | |
| Doctor/Practitioner or Clinic Representative |  |
| Date |  |