

PROGRESSIVE MEDICAL GROUP, INC.
Before-and-After Photography & Image Use Consent

5434 W Capitol Drive, Suite 1, Milwaukee, WI 53216
Phone: 414-251-3500 | Fax: 414-251-3504

Patient Name: _____
Date of Birth: _____

1. PURPOSE OF PHOTOGRAPHY

I understand that Progressive Medical Group may take photographs of the treatment area before, during, and/or after an aesthetic treatment.

Photographs may be used for:

- Clinical documentation
- Monitoring treatment progress
- Comparing treatment results
- Medical record documentation
- Quality improvement
- Education and training, when separately authorized
- Marketing or promotional purposes, only if I provide permission below

2. CLINICAL PHOTOGRAPHS

I understand that photographs necessary for documentation of my treatment may become part of my medical record and will be maintained according to applicable privacy and medical-record requirements.

3. OPTIONAL MARKETING USE

I understand that permission to use my photographs for marketing or promotional purposes is **voluntary** and is not required to receive treatment.

I authorize Progressive Medical Group to use my photographs for:

- ☐ Website
- ☐ Social media
- ☐ Printed marketing materials
- ☐ Advertising

☐ Other: _____

4. IDENTIFYING INFORMATION

I understand that reasonable efforts may be made to avoid identifying me in photographs used for marketing.

I choose:

☐ **May use photographs without my name or other identifying information.**

☐ **May use photographs with my name/identifying information.**

☐ **Do not authorize marketing use of my photographs.**

5. NO PAYMENT

I understand that I will not receive compensation for photographs used for the purposes authorized above.

6. RIGHT TO REVOKE

I understand that I may revoke my authorization for future use by providing written notice to Progressive Medical Group. I understand that revocation does not affect actions already taken based on my prior authorization.

7. ACKNOWLEDGMENT

I have had an opportunity to ask questions regarding the use of my photographs. I understand that this authorization is voluntary.

Patient/Legal Representative Signature: _____

Date: _____

Provider/Staff Witness: _____

Date: _____