PHOTO / VIDEO RELEASE FORM

I acknowledge that this form seeks my consent for photographs and/or videos to be taken by Lowcountry Orthopaedics, either by my doctor or an authorized representative.

Initials: _____

I understand that my name and/or other personal identifying information will not be included in the images or videos without additional consent. However, I understand that someone may still recognize me from the images or videos.

Initials: _____

By signing this form, I understand that the images and/or videos may be used for the following purposes, including but not limited to:

• Social media, online publishing, and digital advertising
• Print marketing and advertising materials
• Video, television, and other media advertising

By consenting to the release of my images and/or videos, I acknowledge that I have not been promised and will not receive compensation, whether in cash or in kind.

Initials: _____

I understand that I may rescind my authorization for future use or release of my photographs and/or videos by submitting a written request to Lowcountry Orthopaedics.

Initials: _____

PATIENT INFORMATION

Patient Name:	_____
Patient Signature:	_____
Date Signed:	_____

CONSENT: By signing above, I confirm that I have read and understand this Photo/Video Release Form and voluntarily provide my consent as indicated.

WITNESS ATTESTATION

Witness to the above and attestation by Lowcountry Orthopaedics that denial of consent to the release of photographs, images, or videos will not affect the medical care the patient can expect and receive from Lowcountry Orthopaedics, its doctors, or representatives.

Witness Signature:	_____
Date:	_____