Social Media Photo Consent Form

Practice Name: _____ Date: _____

1. Participant Information

Full Name: _____ Email: _____

Phone: _____

If you are signing for someone else (such as a minor):

Name of individual appearing in photos/videos: _____

Relationship: _____

2. Description of Content

I understand that photos and/or videos may be taken that could include my image in the following contexts (check all that apply):

☐ Office of Clinic Environment ☐ Staff of Community Events ☐ Educational or Informational Content
☐ Other: _____

3. Where The Content May Be Used

☐ Social Media Platforms (Instagram, TikTok, etc.) ☐ Practice Website ☐ Email Newsletters
☐ Marketing or Promotional Materials

4. How This Content May Be Used

By signing this form, I understand and agree that:

☐ My image may be edited, cropped, or combined with other content
☐ Text or graphics may be added
☐ My name will not be included unless I give separate permission

5. Duration of Consent

By signing this form, I understand and agree that:

☐ This consent remains valid until revoked in writing.
☐ Revoking consent will not affect content already published or shared.

6. Voluntary Participation

By signing this form, I understand and agree that participation is completely voluntary and that my decision will not affect my care, employment, or relationship with the practice in any way.

7. Release and Acknowledgement

I acknowledge that I have read and understand this form and agree to the use of my image as described above. I release the practice from claims related to the approved use of these images.

8. Signature

Printed Name: _____

Signature: _____

Date: _____

Parent/Guardian Name (if applicable): _____

Parent/Guardian Signature (if applicable): _____

HIPAA Note: This consent form does not authorize the disclosure of protected health information. Additional authorization may be required if content includes identifiable health details.