

Patient Consent / Release Form

I hereby grant permission for the use of any record, illustration, photograph or other imaging record created in my case, for use in examination, testing, credentialing and / or professional certifying purposes.

Print Name

Email

Primary Care Doctor (PCP):

Pharmacy name:

Pharmacy address:

Date

In addition, I grant permission for the use of photographs to be used in any advertisement, including the use of photographs on the professional website of the above stated physician as well as Facebook, Instagram and Active Campaign upon request.

Print Name

Patient Signature