INCREDIBLE

PHOTO & MEDIA CONSENT FORM

Consent Waiver

(PIPEDA & PHIPA Compliant)

Client Name: _____ Date of Birth: _____

Date: _____

1. PURPOSE OF CLINICAL PHOTOGRAPHY (MANDATORY)

I understand and acknowledge that clinical photography is a required component of my aesthetic/medical treatment at this clinic. These photographs may include images taken before, during, and after treatment and constitute my Personal Health Information (PHI).

Clinical photographs are collected for:

- Treatment planning and assessment
- Monitoring treatment progress and outcomes
- Medical documentation and continuity of care
- Quality assurance and practitioner education

2. COLLECTION, USE & DISCLOSURE OF PERSONAL HEALTH INFORMATION

I acknowledge that my photographs constitute Personal Health Information as defined under:

- Personal Information Protection and Electronic Documents Act (PIPEDA)
- Personal Health Information Protection Act (PHIPA) (where applicable)

I understand and agree that:

- My photographs will be collected, used, and disclosed only for identified clinical purposes
- Images will be retained as part of my confidential medical record
- Access to my photographs will be limited to authorized clinic personnel

Reasonable administrative, technical, and physical safeguards are in place to protect my information from unauthorized access, loss, or disclosure. My photographs will not be disclosed to third parties.

3. CONFIDENTIALITY & RETENTION

I understand that:

- My identity will remain confidential
- Photographs will be retained in accordance with applicable record retention laws

I have the right to request access to, or correction of, my personal health information in accordance with applicable legislation.

4. MARKETING & PROMOTIONAL USE – SEPARATE & OPTIONAL CONSENT

I understand that clinical consent does NOT include marketing or promotional use.
Any use beyond my care requires separate, express consent, which I may grant or refuse without affecting my treatment.

☐ **OPTION A – I CONSENT TO MARKETING USE**

I voluntarily authorize the clinic to use my photographs for marketing, advertising, promotional, or educational purposes, which may include:

- Clinic website and digital platforms
- Social media
- Print or digital marketing materials
- Professional or educational presentations

I understand that:

My name and identifying information will not be disclosed, and I will not receive compensation.
This consent may be withdrawn in writing at any time, subject to materials already in circulation.

Client Initials: _____

☐ **OPTION B – I DO NOT CONSENT TO MARKETING USE**

I do not authorize the use of my photographs for marketing or promotional purposes. My images will remain part of my confidential medical record only.

Client Initials: _____

5. WITHDRAWAL OF CONSENT

I understand that I may withdraw or modify my consent for the collection, use, or disclosure of my personal health information at any time by providing written notice, subject to legal and contractual restrictions.

6. ACKNOWLEDGMENT & SIGNATURE

I confirm that:

- The purpose of photography has been explained to me
- I understand how my personal health information will be used and protected.
- My consent is knowledgeable and voluntary.

Client Signature: _____ Practitioner Name: _____

Printed Name: _____ Signature: _____

Date: _____ Date: _____