Photo and video release form

AviClear™

I hereby give my permission to Cutera, Inc. (physician/company) _____ and his/her employees, or any person, firm or organization that he/she may designate to take photographs, digital images and/or videos of me (patient name) _____ or, if applicable, my (son/daughter name) _____.

This consent includes the use of such photographs, images or videos without my name for procedure evaluation, patient discussion and medical educational purposes regarding the AviClear™ procedure. Additional acceptable uses for such images and videos are initialed below.

Photo book _____
Website or social media sites _____
TV broadcast _____
Digital/print article or publication _____
Advertisement _____

_____ _____
Patient name Name of parent/guardian if applicable

_____ _____
Signature Date

_____
Witness name

_____ _____
Witness signature Date