

# CONSENT FOR PHOTOGRAPHY AND AUTHORIZATION FOR USE AND DISCLOSURE

Patient's Name: \_\_\_\_\_

ID / Passport Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## 1. Consent for Photography

I hereby give my consent to be photographed during the provision of medical-aesthetic treatment at the clinic and/or by Dr \_\_\_\_\_.

The term "photography" includes still or moving images (photographs, videos, or other formats), in either digital or physical form.

## 2. Authorization for Use and Disclosure

I authorize the use and/or disclosure of the photographs taken by \_\_\_\_\_ (name of the clinic and/or doctor) and by **LABORATORIO INNOAESTHETICS, S.L.U.**

## Authorized Purposes

The images may be used for:

- Clinical documentation and follow-up of my treatment.
- Educational, scientific, or research purposes.
- Publications and presentations at medical congresses.
- Communication, marketing, public relations, or media purposes related to the clinic or to **LABORATORIO INNOAESTHETICS, S.L.U.**

I hereby grant the rights to my image solely for the purposes described above and waive any right to financial compensation.

Whenever possible, images will be processed in a way that prevents patient identification (for example, by avoiding showing eyes or other identifiable facial features).

## 3. Liability Waiver

I release \_\_\_\_\_ (name of the clinic), \_\_\_\_\_ (name of the doctor), **LABORATORIO INNOAESTHETICS, S.L.U.**, and any other person involved in my care, as well as their successors and assignees, from any liability arising from the authorized use of these images.

#### 4. Patient Rights

- I may request that the use of my images be discontinued or revoke this consent at any time by sending a written communication to the clinic and to **LABORATORIO INNOAESTHETICS, S.L.U.**, via email at: [protecciondatos@innoaesthetics.com](mailto:protecciondatos@innoaesthetics.com).
- Revocation will not have retroactive effects on uses already made.
- I have the right to access, rectify, or delete my personal data, as well as to exercise the rights of restriction, portability, and objection, in accordance with Regulation (EU) 2016/679 (GDPR) and the Spanish Organic Law 3/2018 on the Protection of Personal Data and Guarantee of Digital Rights.
- I understand that I will not receive any financial compensation for the use of the images.
- I will receive a copy of this consent form.

#### 5. Validity

This consent shall remain valid until it is expressly revoked in writing.

**Place and Date:** \_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_

**Responsible Physician's Signature:** \_\_\_\_\_