

LOSE FOR LIFE Photography and Testimonial Consent Form

Patient's Name: _____

DOB: _____

I hereby give consent to have my before and after pictures taken while in the LOSE FOR LIFE Weight Management Program. I may receive a copy of these pictures when I complete the program and have a right to ask for these if they are not provided. A copy may also be sent to my Primary Care Physician at the end of the program and may be shown to other Infinity Primary Care physicians or team members to show the success of the program.

Signature: _____

Date: _____

Once I see the before and after picture, I may be asked if the picture can be used for:

- The wall of fame, which includes framed pictures of participants who lost weight in any 50 lb. increment.
- The Infinity Primary Care Wellness Center Website

I hereby give my consent for these pictures to be used in the methods as indicated.

Signature: _____

Date: _____

I hereby give my consent for the Infinity Primary Care (IPC) Wellness Center (WC) to use all or part of my testimonial on IPC WC's website and/or for other internal use. This is used to provide information to interested parties about the success that LOSE FOR LIFE participants have had on or after the program. I understand that my before and after weight or other measurements may be used but that all other identifying information including my name will not be used unless I check the following boxes:

- Feel free to use my first name
- Feel free to use my initials

Signature: _____

Date: _____