Cary D. Nelson, M.D.
M.O.S. Medical, Inc.
Skinetics, Inc.
725 W. La Veta Avenue, #250
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PHOTOGRAPHY RELEASE FORM

The undersigned hereby authorizes CARY D. NELSON, M.D. AND DESIGNATED SKINETICS STAFF to take photographs of me and use them as an aid in my treatment. I understand that these photographs will help document the progress of my treatment. I hereby authorize and consent to the above-described photography.

____

(Patient's signature) (Date)

I hereby authorize and consent to the above-described photography being used by my physician for marketing or study reporting purposes, and that any photographs taken will remain the property of the facility. If used for any of these purposed, I understand that my identity will be kept strictly confidential – no names will be released.

____

(Patient's signature) (Date)

All photographs are an integral component of the patient medical record and are protected by privacy law pursuant to H.I.P.A.A. federal standards.