

**CARA MIA MEDICAL DAY SPA  
LESLIE R. CAPIN, M.D.**

**PERMISSION TO USE TREATMENT PHOTOGRAPHS**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Medical photography is important for documentation and treatment and I have given permission for my photographs to be taken. I also give my permission for the photographs related to my treatment to be used for marketing purposes by *Cara Mia Medical Day Spa*. I understand that *Cara Mia Medical Day Spa* will attempt to keep my identity confidential.

\_\_\_\_\_  
Patient Signature Date