PATIENT PHOTOGRAPHY RELEASE FORM

Patient Name:

I, _____, authorize my physician and staff representatives, to take photographs of my body for medical purposes to be used for my patient care, marketing, literature and/or case presentations.

I understand that:

» Photographs are taken to capture treatment outcomes for the CoolSculpting® procedure.

» They may be used for print, visual or electronic media including but not limited to, scientific presentations, websites and for purposes of informing the medical profession or general public about the procedure. These uses may also include marketing on behalf of the physician's practice.

» I will not be identified by name in any of the published materials.

» My face will not be shown in the photographs nor will they reveal my identity.

» I have the right to revoke this authorization in writing at any time through a written revocation to my physician and ZELTIQ.

» I authorize my photos to be released to ZELTIQ Aesthetics, Inc. ("ZELTIQ") and may be used for print, visual or electronic media including but not limited to, scientific presentations, websites, general marketing, and for purposes of informing the medical profession or general public about the CoolSculpting procedure on behalf of ZELTIQ.
Yes____ No _____

» The images taken of me may be published by the physician. **Yes ____ No ____**

» The images taken of me may be published by ZELTIQ and their agents and representatives. **Yes____ No____**

I hereby release my physician, ZELTIQ and their agents and representatives from any and all claims and demands arising out of, or in conjunction with, the use of the photographs.

I certify that I have read this release carefully and fully understand its terms.

Print Name: _____ Signature: _____Date: _____

Witness: _____ Date: _____