Photo Release Form

I ____________________________ give my permission for Zmedi Healthcare dba/ Zamara Medical Aesthetics, to post any videos or photos of services performed on me and any relating descriptive information obtained on me to its social media sites including but not limited to its website, Instagram and Facebook.

Please select one:

I am18 years of age or older

I am under the age of 18

Full Name____

Street Address/P.O. Box_______________________________________

City ____

Prov/Postal Code/Zip Code______________________________________

Phone _________________________ Fax _____________________

Email Address____

Signature__________________________ Date_____________

If this release is obtained from anyone under the age of 18, then the signature of that individual's parent or legal guardian is also required as authorization.

Parent's/Legal Guardian Signature_________________________________

Date____

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Palos Heights, IL 60463
708.560.3059

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