Authorization to Release Patient Record Information

I, _____, hereby authorize ***Anderson Orthodontics*** to disclose facial and/or dental photographs, photographs, and video of the following patient as approved below:

Patient Name: _____ **Patient DOB** _____/_____/_____

Please check the appropriate answer to each of the following questions:

1. May the patient's picture be displayed on the ***reception computer screen*** for patient sign-in purposes?
   ☐ Yes ☐ No
2. May the patient's picture be displayed ***on the office website, Blog, Facebook account and/or within the office*** for the purpose of informing patients of the positive outcome we have achieved?
   ☐ Yes ☐ No
3. May the patient's picture be displayed ***on the office website, Blog, Facebook account and/or within the office*** if they are a contest prize winner?
   ☐ Yes ☐ No
4. May the patient's records including photographs be used for the purposes of professional consultations, research, education or publication in ***professional journals***?
   ☐ Yes ☐ No

Please Note:

Financial Disclosure: I understand that the practice is not receiving compensation from anyone for use of the patient's photo.

Refusal to Sign: I understand that refusal to sign part or all of this Authorization will in no way affect the patient's treatment.

Revocation: I understand that I may revoke this authorization at any time by sending a written notice to the practice. All photos will be removed at the time the revocation is received.

Certification:

☐ I certify that I am the authorized representative for the patient. *My relationship to the patient is:*

_____

☐ I certify that I am the patient.

Signature:_____

Date: _____

Witness:_____

Date: _____