Authorization for use of Photograph (s)

This office displays photographs of patients for the purpose of treatment and patient relations. Before a patient's photograph (s) is used, permission is obtained from the patient and the use of the photograph (s) is held to specific conditions.

Conditions

- The photograph (s) is to be displayed in a professional manner at this location only.
- Patient's personal information associated with the photograph (s) will be restricted.
- The photograph (s) will not to be displayed for marketing or commercial purposes outside of this office.
- If the photograph (s) is used for teaching treatment procedures, the photograph (s) will be altered to protect the identity of the patient.
- This authorization and the use of the patient's photograph (s) will terminate upon the completion of treatment.
- Patient has the right to revoke the use of their photograph (s) at anytime.

Authorization

By signing this authorization, you are permitting the use of your photograph (s) base upon the conditions of this authorization.

You understand that any changes in the conditions of this authorization and/or use of your photograph (s) will automatically terminate this authorization and the use of your photograph (s). You also understand that you may revoke this authorization and the use of your photograph (s) in writing at anytime.

I _____ (patient's name) have read this authorization and therefore give permission for the use of my photograph (s). By doing so, I release this office of any liability that may result from the use of my photograph (s)

_____

Patient's Signature Date

If the patient is a minor (under 18 years of age), a parent or legal guardian must sign.

_____

Parent or Guardian's Signature Date