VALDERRAMA
ORTHODONTICS

PHOTO RELEASE FORM

I, _____ (patient name or legal guardian) hereby authorize **Valderrama Orthodontics** to take photographs and videos of my face, jaws and teeth before, during and after my orthodontic treatment. I understand that the photographs and videos will be used as a legal record of my care, and may be used for communication with other health care professionals, only when required for the successfully completion of my orthodontic treatment.

I consent to allow the photographs to be used for the following purposes:

_____ Dental Records

_____ Dental Research

_____ Patients Education

_____ Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books.

_____ Marketing material, including website and printed materials.

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.

I have read the foregoing in its entirety and understand its terms.

Signature: _____ Date: _____

Parent/Guardian Name (for minors): _____

Witness: _____ Date: _____