WAKE ORTHODONTICS AND PEDIATRIC DENTISTRY

Authorization for Release of Photographs

Name of Patient_____ Date of Birth_____

Wake Orthodontics and Pediatric Dentistry is authorized to release photographs of the above named patient to the entities below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Photographs:

Facebook  Our Website  Instagram  YouTube

Check each entity that you approve.

I understand that I have to the right to refuse to sign this authorization. This authorization shall be in effect until revoked by patient.

_____ **Date**_____

Signature of Patient or Personal Representative