

Authorization for Release of Photographs

Wake Orthodontics and Pediatric Dentistry

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:



Our Website



Facebook



Instagram



Twitter



Pinterest

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

