

## **Photo Release**

**Must be signed by the patient and/or the parent.**

I consent to the taking of records, including photographs, and x-rays, before, during, and after treatment, and to the use of the records by my doctor in scientific papers, demonstrations, and all forms and media.

Patient's name \_\_\_\_\_ Signature \_\_\_\_\_

Parent's name \_\_\_\_\_ Signature \_\_\_\_\_

Doctor's name \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_

*Return to:*

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Via Fratelli Cairoli 82 50131 Firenze

Italy

fax +39 055 390 90 14 e-mail: editor@vjo.it