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_____

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