LEGACY ORTHODONTICS

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Photo Release Form

Name of Patient ("Releasor"): _____

If a patient is a minor, Name of Parent/Guardian: _____

1. I consent to the unrestricted use by Legacy Orthodontics and those acting with its permission. For all purposes, in any form, and in any and all media (whether now known or hereafter devised), including but not limited to social media, advertising, solicitation, website, and stock photography.

2. I waive any right to inspect or approve the finished image, advertising copy, text, or other materials in relation to photographs or videos taken of me by The Practice and those acting with its permission.

I acknowledge that I have read and understand this release.

_____

Signature of Releasor, or Releasor's parent/ Guardian: **Date:**

_____ _____

☐ In office use only _____ (Initials of Parent/Guardian)

☐ No photos _____ (Initials of Parent/Guardian)