STATEN ISLAND
ORAL & MAXILLOFACIAL SURGERY

AUTHORIZATION TO RELEASE PHOTOGRAPHS

Patient's Name: _____ Date of Birth: _____

SSN: _____

Doctor's Name: _____

Practice Name: _____

I authorize the above listed doctor and practice to release any and all photographs/videography taken of the patient named above for the following uses:

___ Educational Journals

___ Teaching Purposes

___ Website

___ Other _____

This request and authorization applies to photographs taken for the following treatment, condition, or dates of treatment: _____

I acknowledge that prior to my agreeing to the above x-rays or photos of my mouth appeared on materials to promote an academic seminar.

Patient Signature: _____ Date: _____

_____ Date: _____
Doctor's Signature

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