JAMES RIVER
FAMILY DENTISTRY

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT PHOTOGRAPHIC AND/OR VIDEO IMAGES

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I further agree I will not assert any claims against any party whatsoever based on the usage of the images or make any claim to the usage of the images that constitutes an infringement on my right to privacy or any other right I may enjoy.

Patient Name: _____

Date: _____

Signature: _____

If Patient is a Minor:

Parent/Legal Guardian: _____

Date: _____

Signature: _____

If Personal Representative:

Name: _____

Date: _____

Signature: _____

Relationship to Patient: _____