Patient Photo Release Form:

I _____, hereby authorize Dental Park of McAllen 2, PLLC, or any of their assignees to take photographs, slides, and videos of my teeth, jaws, and face. I understand that the photographs, slides, and videos will be used as a record of my care, and may be used for communication with other healthcare professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, facebook posts, etc.).

I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information (first name only) may be used unless stated differently below. I do not expect compensation, financial or otherwise for the use of these photographs. If I wish to revoke this consent I will do so in writing.

Please **Initial only one** of the following:
_____ I do not mind if my photographs are used in any of the above stated situations.
_____ I agree to have my pictures shown with no identifying information.
_____ I only agree to have my teeth shown without any identifying features.
_____ I do not agree to any publication of any of my photos.

_____ _____
Patient's name Patient/Parent/Responsible Party Signature

Release of Records Consent:

I, the undersigned, hereby authorize the doctor and/or designated assignees to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs, I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employ any such assistance as he/she deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me and my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

_____ _____
Patient/Parent/Responsible Party Signature Date