Child's Photo Special Authorization

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SPECIAL AUTHORIZATION - CHILD'S PHOTO'S

I, _____, consent to allow Pediatric Dentistry of Ft. Myers

to use my child's (_____) (Name of Child):

(check all that apply)

- ☐ Photo's
- ☐ Dental / Medical Photos
- ☐ Radiographs
- ☐ Study Models
- ☐ TMJ Score
- ☐ And other information (please describe): _____

From my child's dental record for (check all that apply):

- ☐ Website Marketing
- ☐ Scientific Papers
- ☐ Lectures
- ☐ Demonstrations and other educational events
- ☐ Other (please describe): _____

My child's name will not be published.

I have been informed that I am not required to sign this consent.

I understand I am not financially compensated for this authorization.

This consent may be revoked by written notice delivered to Pediatric Dentistry of Fort Myers within 30 days of my signature. This special authorization expires on _____.

Pediatric Dentistry of Ft. Myers

By: _____
Authorized Staff Member Date

_____
Patient Date

_____
Print Patient name Date

_____
Guardian / Parent Date