



TELL US ABOUT YOU!

Photo Release

WE WILL BE DOCUMENTING YOUR SMILE TRANSFORMATION WITH PHOTOS, POSSIBLE VIDEOS AND DENTAL MODELS TO CELEBRATE YOUR RESULTS. WE OCCASIONALLY SPOTLIGHT PATIENTS ON OUR WEBSITE, WITHIN THE OFFICE, AND OTHER PRACTICE SITES (FACEBOOK, BLOG, ETC) AND REQUEST YOUR AUTHORIZATION BELOW.

I, THE UNDERSIGNED, DO HEREBY RELINQUISH ANY AND ALL RIGHTS TO PHOTOGRAPHS, PORTRAITS, PRINTS, NEGATIVES, OR OTHER PHOTOGRAPHIC REPRODUCTIONS CAPTURED WITH STILL MOTION PICTURE, VIDEO, DIGITAL OR OTHER CAMERAS FOR USE BY HAMILTON ORTHODONTICS.

PATIENT NAME

PATIENT SIGNATURE

PARENT/GUARDIAN NAME AND SIGNATURE (IF PATIENT IS UNDER THE AGE OF 18)

Acknowledgement of Receipt of Notice of Privacy Practices

***YOU MAY REFUSE TO SIGN THIS AGREEMENT.**

I, _____ HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

PLEASE PRINT NAME

SIGNATURE

DATE

For Office Use Only

WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES, BUT ACKNOWLEDGEMENT COULD NOT BE OBTAINED BECAUSE:

- INDIVIDUAL REFUSED TO SIGN
- COMMUNICATION BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGEMENT
- AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING THE ACKNOWLEDGEMENT
- OTHER (PLEASE SPECIFY)

DOCTOR SIGNATURE _____ DATE: _____