NOBLE MCCLINTOCK
ORTHODONTICS

I, _____ (Patient name), hereby authorize Noble McClintock Orthodontics to take photographs and/or videos of my face, jaws and teeth before, during and after treatment.

I consent to allow the photographs to be used for the following (Please initial):

___ Dental records or education

___ Marketing material and advertisements, including limited use on social media, websites, printed materials, and in-office demonstrations

___ **I do not consent to photos and/or videos.**

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of my photographs and/or videos.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Signature: _____ Date: _____

Patient/Parent/Guardian (If minor)