WAZIO ORTHODONTICS
JOHN WAZIO JR. DDS, MS

Photography Release

I, _____,
(Legal Guardian)
Hereby authorize Dr. John Wazio or his staff to take photographs, slides, and/or videos of _____'s face, jaws, mouth, and teeth.
(Patient's Name)

I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in study club meetings, lectures, seminars, demonstrations, and professional publications (journal, magazines), Wazio Orthodontics website (www.wazioorthodontics.com) or the Wazio Orthodontics Facebook page.

I understand that if my photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs. I release Wazio Orthodontics and its employees and legal representatives from any and all claims, actions and liability relating to use of said photographs.

I have the right to restrict the use of photographic images as indicated here _____
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Signature _____

Date _____

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