Authorization to Release Patient Record Information

I, _____, hereby authorize Granbury Oral and Facial Surgery, to disclose facial and or dental photographs of the following patient as approved below:
Patient name : _____ Patient DOB : ____/____/_____

Please check the appropriate answer to each of the following questions:

1. May the patient's picture be displayed on the reception computer screen for patient sign-in purposes?
   ___ Yes ___ No
2. May the patient's picture be displayed on the office website, Facebook, Instagram account and/or within the office for the purpose of informing patients of positive outcome we have achieved?
   ___ Yes ___ No
3. May the patient's picture be displayed on the office website, Facebook, Instagram and or within the office if they are contestant prize winner?
   ___ Yes ___ No
4. May the patient's records, including photographs be used for the purposes of professional consultations, research, education, or publication in professional journals?
   ___ Yes ___ No

Please note :

Financial Disclosure : I understand that the practice does not receive compensation from anyone for use of the patient's photo.
Refusal to sign : I understand that refusal to sign part or all this authorization will in no way affect the patient's treatment.
Revocation: I understand that I may revoke this authorization at any time by sending a written notice to the practice/ All photos will be removed at the time of the revocation is received.

Certification:

I certify that I am the authorized representative for the patient. My relationship with the patient is: _____
I certify that I am patient
Signature: _____
Date: _____
Witness: _____
Date: _____