Photo Release

Must be signed by the patient and/or the parent.

I consent to the taking of records, including photographs and x-rays, before, during, and after treatment, and to the use of the records by my doctor in scientific papers, demonstrations, and all forms and media.

Patient's name _____

Signature_____

Parent's name _____

Signature_____

Doctor's name _____

Signature_____

Date_____

Sign, scan, and upload under the appropriate submission item type with your manuscript in the online submission system.