River City Pediatric Dentistry

Ponte Vedra Pediatric Dentistry & Orthodontics

PHOTO RELEASE FORM

I, _____, parent and/or guardian hereby give River City Pediatric Dentistry, P.A., Ponte Vedra Pediatric Dentistry & Orthodontics, P.A. and their legal representatives and assigns, the right and permission to publish, without charge, photographs taken at River City Pediatric Dentistry and/or Ponte Vedra Pediatric Dentistry & Orthodontics.

These photographs may be used in publications, including electronic publications, or in audiovisual presentations, promotional literature, advertising, or in other similar ways.

We hereby warrant that we are over eighteen (18) years of age, and are competent to contract in our own name or a parent and/or guardian will sign.

_____ Check here if only giving a release to take photo for dental chart records.

Patient name: _____

Patient name: _____

Patient name: _____

Parent/Guardian Signature: _____

Name of person signing this form (please print): _____

Relationship to child: _____

Disclaimer: Above information is held in confidence and is never released or sold.