LARSON ORTHODONTICS

Dr. Douglas M. Larson
Dr. James M. Larson
680 Fairmount Ave., W.E.
Jamestown, NY 14701
(716) 483-1718

RELEASE AUTHORIZING USE OF PERSONAL LIKENESS

I, _____ (patient/parent/guardian name) consent to the use of my personal image and likeness, including but not limited to images representing and depicting the treatment provided to me and the effect thereof, by **Dr. Douglas Larson** for any lawful use **Dr. Douglas Larson** deems appropriate, including for treatment, advertising his/her/its services to the general public **(including via social media and electronic media),** illustration, and publication to the public at large for educational purposes.

I hereby relinquish any and all rights to my likeness or any image of me obtained by any photographic or digital means by **Dr. Douglas Larson** during the course of my treatment. I understand that I am entitled to no consideration, remuneration or payment for the use of my image in any advertising, promotional or educational materials.

I understand any image or likeness of me may be altered prior to use if deemed appropriate by **Dr. Douglas Larson.** I understand and agree that I have no right to be consulted about or approve of any such alterations before my image is used.

I understand that **Dr. Douglas Larson** will make all reasonable efforts to safeguard my privacy as required by applicable law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand, however, that **Dr. Douglas Larson** cannot guarantee my complete privacy in the event my image or likeness is used by third parties.

I understand and agree that **Dr. Douglas Larson** may use information regarding my health condition, including information regarding my diagnosis, course of treatment, my date of birth and/or age and my other relevant medical conditions, in describing the treatment rendered to me as depicted in any image of me.

I understand that **Dr. Douglas Larson** may not and has not conditioned the rendition of treatment to me upon my authorization of the use of my image and/or likeness.

I have read the foregoing in its entirety and understand its terms.

_____

Patient name Patient/guardian signature **Date**

_____

If patient is a minor, guardian name relationship to patient **Date**