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**CONSENT TO THE TAKING AND USE OF PHOTOGRAPHS/X-RAYS**

**Name of Patient** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DOB**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby consent to and authorize The Orthodontic Centre at Northland and its employees to record by means of still photographs of the above named patient and to reproduce, exhibit or publish these works for the purposes set out herein.

**Please check the boxes below to indicate your consent.**

[ ]  For use by our office and any of your other health care providers for the purpose of diagnosis and documentation of treatment progress

[ ]  Share with other health care professionals, scientific or professional publications, at lectures, or in exhibitions to scientific or medical audiences

[ ]  To be used for publication on our website, other social media and/or marketing purposes

I hereby waive any, and all claims which I may at any time have against The Orthodontic Centre at Northland or its employees, in any matter whatsoever relating to the said photographs.

I represent that I am the parent/person having lawful custody of the above named patient. I hereby consent to the foregoing on the patient’s behalf.

**READ BEFORE SIGNING**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Authorized Person Date (month/day/year)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness Date (month/day/year)

If the Authorized Person is not the

Patient, state relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_