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**PERMISSION TO USE X-RAYS, PHOTOGRAPHS AND VIDEOS**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Jorge Alvarez, DDS and/or his assistants to take x-rays, photographs and/or videos of me, including without limitation my face, teeth, smile and dental conditions. These materials may reveal my name and identity.

These x-rays, photographs and/ or videos will become the property of Jorge Alvarez, DDS. They may be published in dental journals, shown for educational purposes, showcased in the dental office, disseminated on the internet or social media, displayed in advertising, used on a website and/ or used for other commercial purposes. I authorize Jorge Alvarez, DDS to reveal my name, identity and the fact that I am his patient.

I waive any right to claim a confidential, proprietary or other interest in these materials or any financial or other benefits gained from their use.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_