Brodie L. Bowman, DMD
Specialist in Orthodontics & Dentofacial Orthopedics
CHILDREN + TEENS + ADULTS

# AUTHORIZATION TO RELEASE PATIENT RECORD INFORMATION

I,_____ hereby authorize Dr Brodie L. Bowman to disclose facial and/or dental photographs of the following patient as approved below:

Patient Name: _____
Patient Date of Birth: _____

Please check the appropriate answer to each of the following questions:

1.) May the patient's picture be displayed on the office website, social media outlets and/or within the office for the purpose of informing patients of the positive outcome we have achieved?

☐Yes ☐No

2.) May the patient's picture be displayed on the office website, social media outlets and/or within the office if they are a contest prize winner?

☐Yes ☐No

3.) May the patient's records including photographs be used for the purposes of professional consultations, research, education or publication in professional journals?

☐Yes ☐No

Please Note:

Financial Disclosure: I understand that the practice of Dr Brodie L. Bowman is not receiving compensation from anyone for the use of the patient's photo.

Refusal to sign: I understand that refusal to sign part or all of this Authorization will in no way affect the patient's treatment.

Revocation: I understand that I may revoke this authorization at any time by sending a written notice to the practice. All photos will be removed promptly once the revocation is received.

Certification:

I certify that I am the patient.

I certify that I am the authorized representative for the patient.

Relationship: _____

Signature _____ Date _____ Signature _____ Date _____