



**FLORIDA
DENTURE
INSTITUTE**

A reason to smile again.

Authorization for Release and/or Publication of Videography and Photography

I hereby authorize the release and/or publication of videos and photographs that may be taken preoperatively, during surgery, and postoperatively, without limitation regarding my physical and mental condition. I consent to these videos and photographs, also being available for:

- 1. Patient Viewing _____(initials)
- 2. Advertising _____(initials)

Name of Patient

Date

Patient's Address

City

State

Zip Code

Patient or Legal Guardian

Date

Witness Signature

Date