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ORTHODONTICS & ORTHOTROPICS

Aligne Orthodontic and Orthotropics
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Authorization Form:

_____
Patient Name

YES NO

I give permission to Aligne Orthodontics and Orthotropics to use my records (photographs, X-rays, models etc..) for educational purposes, such as but not limited to study club meetings, lectures, classes, seminars, demonstrations.

YES NO

I give permission to Aligne Orthodontics and Orthotropics to use my records (photographs, X-rays, models etc..) for promotional purposes, such as but not limited to website, flyers, patient education. I will be able to review such materials before it goes to the public. I understand that my identity (name, age, etc.) will be kept confidential, unless otherwise noted on a separate release.

Signature:_____**Date:**_____