ageless in the triad med spa

Advanced Oral & Facial Surgery OF THE TRIAD

Teresa G. Biggerstaff, DDS, MD, P.A.

Authorization to Release Photographs

Patient's name: _____ Date of birth: _____

Previous name: _____

I authorize Ageless in the Triad, Advanced Oral & Facial Surgery of the Triad, Avery Carrigan, FNP-C, and/or your practitioner to release any and all photographs taken of the patient named above for the following uses: social media, office photo gallery, submission for educational purposes and/or other.

I understand that I will not be identified by name in these photographs. Every attempt will be made to cover-up or remove identifiable features (such as tattoo); however in some circumstances, the photograph may portray features which make my identity recognizable.

This authorization may be revoked in written form to the extent allowed by law. If I do revoke this authorization, I understand that the practice or practitioner may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of photographs by the doctor or practice in reliance on my original authorization.

To cancel this agreement, I must:

- Write a letter to the practice or practitioner advising of my wish to cancel my authorization to disclose photographs taken of me by this practice. I (or my authorized representative) must sign and date the letter.

Once the practice or practitioner has released my photograph, I know that they have no control over them. Federal or state privacy laws may no longer protect the information.

_____

Signature of patient or patient's authorized representative Date signed

_____

Relationship or status if signed by parent, legal guardian, personal representative, etc.

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