MICHAEL J. WALL DMD MS
specialist in orthodontics

Pictures Tell The Story: PHOTO RELEASE FORM

We love the results of your orthodontic treatment! You have done a fantastic job and we would love to show off your smile and what you did to help educate others that may have a similar problem. With your permission we would like to use your photographs for patient education, and for use on our website - www.drwall.net. Those who have viewed our website have given us great reviews and said that it is very educational. They are happy to see beautiful smiles. Viewers can relate to others that have had similar problems and are happy to find that there are beautiful solutions to their problems. We are tactful and we will not use your name unless you allow it.

CHECK IT OUT! www.drwall.net

PHOTO RELEASE

I, the undersigned, do hereby relinquish any and all rights to photographs, portraits, prints, or other photographic reproductions captured with digital or other cameras for use by the office of Michael J. Wall, DMD, MS.

Select Any or All that apply:

☐ **I love my new spectacular smile and I am happy and proud to show it off for patient education in the offices of Dr. Michael J. Wall; for use in office promotional materials; and office website www.drwall.net**

☐ **You may use my NAME along with my photos. A testimonial to my great smile! (We celebrate your success. Recognition for models, musicians, athletes, brains! - We are happy to promote you, your career, your business, and your website. Tell us if you want a website link.)**

Limited Uses: I authorize the use of my photos, but for limited uses:

☐ **For patient education inside the physical offices of Dr. Michael J. Wall only.**

I authorize the use of some of my photos, but limit it to:

☐ **only facial photos (no tooth close-ups)**
☐ **only finish photos (no beginning photos)**
☐ **photos I give to Dr. Wall's office.**

Thanks for helping us spread the good word about building beautiful smiles with BRACES!

You have a fantastic smile and we want to show it off!

Print Patient's Name:_____

If under 18 years of age:
Parent or Guardian
Signature:_____Date:_____

Please mail this form along with your photo to:

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