

Release and disclosure of my dental information

I, _____, allow Dr. Ryan Kowalczyk of Downtown Dental to use the following dental information for education and marketing reasons at his office and website.

Please check any of the following that you allow Dr. Kowalczyk to disclose:

- Facial photographs
- Oral photographs
- Dental photographs
- Dental charting
- Dental x-rays – includes panoramic, bite-wing, and periapical
- Any dental laboratory work done – impressions, casts, and actual restorations

I understand that checking the facial pictographs box above means that my identity may be disclosed to the patients of Downtown Dental and the public.

I consent to Dr. Ryan Kowalczyk to disclose my dental information.

At any time I can terminate this agreement with Dr. Ryan Kowalczyk by giving him a written notice effective immediately.

Signature:

Date:
