ACKNOWLEDGEMENT RECEIPT OF PRIVACY POLICY

I, _____, have received a copy of this office's Notice of Privacy Practices.

Our patients' privacy is important to us here at Smile Fort Worth. You can obtain a copy of our privacy policy at anytime on our website (www.SmileFortWorth.com) or during business hours at our reception desk. If you should have questions regarding our privacy policies please direct those to J. Matt Wilkinson, DMD at (817) 732-6622.

PATIENT NAME (PRINT): _____ DATE: _____

PATIENT SIGNATURE OR GUARDIAN, IF A MINOR: _____

RELEASE OF HEALTH INFORMATION

I am authorizing the release of my dental information to the following persons:

- _____ relation to patient _____
- _____ relation to patient _____
- _____ relation to patient _____

My consent is freely given. I understand that I may revoke this consent at any time in writing, but any disclosures given in reliance on this prior to will be permissible.

PATIENT NAME (PRINT): _____ DATE: _____

PATIENT SIGNATURE OR GUARDIAN, IF A MINOR: _____

RELEASE FOR PHOTOS AND MEDIA RECORDINGS

I, _____, give Drs. Robert Batton, Justin Harlin & Matt Wilkinson permission to use photographs and/or media recordings of me for teaching or training, seminars, social media sites or office brochures. I understand there will be no compensation to me for the use of the photographs and/or recordings.

I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement.

PATIENT NAME (PRINT): _____ DATE: _____

PATIENT SIGNATURE OR GUARDIAN, IF A MINOR: _____