

Dr. Tyler H. Jolley D.M.D • Dr. Zach Pitcher D.M.D, M.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of the Jolley Smiles

notice of privacy practices.

Patient Name: ______ Date: _____ Signature of Patient or Guardian: **MEDIA RELEASE** I hearby authorize Jolley Smiles to publish my name, orthodontic records, photographs, and any videos taken of me for use in their printed publications. website, and online social networking sites. I acknowledge that since my participation in publications and websites producted by Jolley Smiles is voluntary, I will receive no financial compensation. I further agree that my participation in any publication and website producted by Jolley Smiles confers upon me no rights of ownership whatsoever. I release Jolley Smiles, any contractors and the employees from liability for any claims by me or any third party in connection with my participation. Patient Signature: ______ Date: _____ Parent Signature: ______ Date: _____ Street Address: _____ City, State, Zip Code: _____