AUTHORIZATION TO RELEASE AND DISCLOSE PHOTOGRAPHS

By signing this form, I ____ (Patient) am allowing Regeneration, P.C., its affiliates, successors and assignees to disclose photographs taken of me before, during and after treatment.

Please initial either yes or no on each line

For research, educational informational purposes	Yes _____	No _____
For publications in a medical journal and/or textbook	Yes _____	No _____
For general advertising, publicity or promotional purposes	Yes _____	No _____

I hereby release Regeneration, P.C. from any claim demand, cause, action or proceeding of whatever nature arising out of publication and distribution of the said photographs in accordance with the terms of this release. This release also includes affiliates, successors and assignees of Regeneration, P.C.. I also understand that I can revoke (or take away my permission) to allow Regeneration, P.C. to disclose photographs of me to affiliates, successors or assignees. If I send a letter saying that I revoke my authorization, Regeneration, P.C. will not disclose any more photographs of me after the Practice received the letter.

I understand that once my photographs have been disclosed Regeneration, P.C., its affiliates, successors and assignees, the photographs will no longer be protected by federal laws.

However, Regeneration, P.C. its affiliates, successors and assignees will not use photographs except as permitted on this authorization form. I understand that I will be given a signed copy of this form.

I hereby release Regeneration, P.C. its affiliates, successors and assignees, from any claim demand, cause, action, or proceeding of whatever nature arising out of publication and distribution of the said photographs in accordance with the terms of this authorization.

_______________________________ _______________________________ __________

PATIENT NAME, PRINTED PATIENT SIGNATURE DATE