Special Authorization

for patient privacy protection

David R. Musich, D.D.S. & Matthew J. Busch, D.D.S., Ltd

I, _____, consent to allow David R. Musich, D.D.S. & Matthew J. Busch, D.D.S., Ltd to use **my / my son's / my daughter's** (circle one):

- √ dental / medical photos
- √ radiographs
- √ study models
- √ TMJ score
- √ and other information (please describe): _____

from **my**/ **my son's / my daughter's** dental record for (circle one):

- √ In-office Born to Smile board / In-office Digital Display Board
- √ website marketing
- √ scientific papers
- √ lectures
- √ demonstrations and other educational events
- √ other (please describe): _____

I have been informed that I am not required to sign this consent.

I understand I am not financially compensated for this authorization.

This consent may be revoked by written notice delivered to David R. Musich, D.D.S. & Matthew J. Busch, D.D.S., Ltd. within 30 days of signature.

David R. Musich, D.D.S. & Matthew J. Busch, D.D.S., Ltd.
Name of Practice

_____
Patient Date

By: _____
Authorized Staff Member Date

_____
Print Patient Name

_____
Guardian / Parent Date

Please Note: Drs. Musich & Busch are on the faculty of the University of Pennsylvania School of Dental Medicine and may use treatment plans with before & after photographs in their presentations to the orthodontic residents for teaching purposes.

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