Special Authorization

for patient privacy protection

Matthew J. Busch, D.D.S., Ltd.

I, _____, consent to allow 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 Matthew J. Busch, D.D.S., Ltd. within 30 days of signature.

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: Dr. Busch is 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.