Patient Consent

Publication of Records

I authorize Dr. Bechtel to take photos, videos, slides, x-rays or any other viewing of my care and treatment during or after its completion to be used for treatment planning my case, the educational advancement of dentistry, and or insurance reimbursement purposes. By initialing below, I further consent to allow Dr. Bechtel to use my information for promotional purposes and understand that my identity will not be revealed to the public, however, without my authorization.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT

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Date Printed Name and Signature of Patient, Parent, or Guardian

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Date Printed Name and Signature of Witness

____

Date Printed Name and Signature of Doctor

_____ I Authorize Dr. Jonathan Bechtel to use my information for promotional purposes.
Initial

_____ I do not Authorize Dr. Jonathan Bechtel to use my information for promotional purposes.
Initial

_____ I Authorize Dr. Jonathan Bechtel to release my name to the public.
Initial

_____ I do not Authorize Dr. Jonathan Bechtel to release my name to the public.
Initial