Waiver and Consent

I, the undersigned, do hereby authorize and consent to the use of certain photographs/x-rays of me taken by Dr Andrus and his staff and I hereby grant Dr Andrus and his staff permission to reproduce, publish, print, use and distribute copies of such photographs/x-rays either in an official medical publication or in the form of prints, slides or film for use in connection with articles, lectures or television broadcasts dealing with jaw or dental disorders. I specifically waive any claim for invasion of my personal privacy that might accrue to me on account of the use of such pictures without my express consent in each instance.

Patient Signature	
Address	
Prosthodontist's Signature	
Prosthodontist's Address	
Date	