DENTAL SCHOOL
UT HEALTH SCIENCE CENTER™
SAN ANTONIO

Department of Oral and Maxillofacial Surgery

Authorization for use of Photographic and/or Other Images/Video for Non-Treatment Purposes

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I hereby authorize the Department of Oral and Maxillofacial Surgery at the University of Texas Health Science Center San Antonio (UTHSCSA) to take photographs, videotape, or digital images of me. I understand that UTHSCSA may use and release my images to the general public for the following purposes: (1) educational lectures and presentations for health care professionals; (2) scientific publications such as journals or books; (3) patient education materials; (4) broadcast, print or internet media for educational or public interest purposes.

I understand that after release of my images to the general public, they may be subject to redisclosure.

I understand this authorization is voluntary and I may refuse to sign. UTHSCSA may not condition my health care services on the completion of this authorization.

Unless otherwise revoked, I understand that this authorization will expire 50 years from the date of signature. I understand that I may revoke this authorization at any time, except to the extent that UTHSCSA has relied on this authorization, by sending a written statement of revocation that specifically refers to this authorization to:

UTHSCSA
Attn: Administrator, Department of Oral & Maxillofacial Surgery
7703 Floyd Curl Dr, Mail Code 7908
San Antonio, TX 78229-3900

I hereby release UTHSCSA, The University of Texas System and its Regents, officers, agents and employees from any and all liability connected with the capture, use or release of my images.

By signing this authorization I acknowledge that I have read and understand the statements contained herein. I understand that UTHSCSA will provide me with a copy of this signed authorization form upon request

If signed by a Legal Representative: By signing this authorization, I certify that I have the legal authority to serve as this patients's legal representative.*

Patient or Patient Representative Signature	Relationship
Printed Name	Date Signed

* For more information on qualifications to serve as a patient's legal representative, see UTHSCSA Guidlines for Legal Representatives.