

# Chicago Smile Spa

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## X-Ray Release

Patient's Information:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ St: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I, \_\_\_\_\_ hereby authorize Chicago Smile Spa to release my dental records and forward them to specialists, dental labs or other persons that may be determined by Dr Alfe to contribute to my dental care while a patient at Chicago Smile Spa.

I also hereby authorize Chicago Smile Spa to forward my records as to any future request I provide. I will give Chicago Smile Spa written information (via letter, email or fax) as to whom and where to forward my x-rays.

## Photo Release

I \_\_\_\_\_ do hereby give Dr. Gerilyn M. Alfe DMD d.b.a. Chicago Smile Spa my permission to license the images and to use the images in any media for any purpose (except pornographic or defamatory) which may include, among others, advertising, promotion, marketing, educational and packaging for any product or service. I agree that the images may be combined with other images, text and graphics, and cropped, altered or modified.

Photos to include:

Media types to exclude:

Full face – pre-treatment	Yes	No
Full face – post-treatment	Yes	No
Smile – pre-treatment	Yes	No
Smile – post-treatment	Yes	No

Advertising	_____
Website	_____
Office	_____
Promotions	_____
TV	_____
Educational	_____

Additional comments to this release:

If name is to appear, please print how you would like it:

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_