

**Dr. Steven R. Schwartz
NY Oral & Maxillofacial Surgeon, PC**

Photographic Consent/Release

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I hereby release and discharge Dr. Schwartz from any and all claims and demands arising out of or in connection with the use of the photographs, including any and all claims for libel.

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I am over the age of eighteen. I have read foregoing and fully understand the contents thereof.

SUBJECT:

Signed: _____

Print Name: _____

Date: _____