

**ANGELA ALLEVATO MD**  
**431 S. BATAVIA ST. STE 203**  
**ORANGE, CA 92868**

**Email- [Drallevato@ocpediatrician.com](mailto:Drallevato@ocpediatrician.com)**

**Phone (714) 639-0662, Fax (714) 639-0660**

### **PHOTOGRAPHY RELEASE FORM**

I grant permission to **Angela Allevato MD** and its agents or employees to use photographs I have provided of my children and myself. I hereby agree to release, defend, and hold harmless **Angela Allevato MD** and its agents or employees. These images may be posted in the office. (These images will not be posted online or on social media).

I am 18 years of age or older and have read this release before signing below, fully understanding the contents, meaning, and impact of this release. I understand that I am free to address any specific questions regarding this release by contacting Dr. Allevato's office, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release. This release form will be effective until revoked in writing by legal guardian.

---

Name (please print) (parent and patient(s) names)

---

Signature (Parent or Legal Guardian)      Date