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## CONSENT TO DENTAL PHOTOGRAPHY

I, \_\_\_\_\_ (Patient), authorize Legacy Dental Studio to take photographs, and/or videos of my face, jaws and teeth, before, during and after treatment.

I consent to allow the photographs to be used for the following:

Dental Records

Dental Research

Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books. Marketing material, including websites and printed materials, patient education

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

Type your name here if you do not want your full face shot used for any of the above purposes

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\_\_\_\_\_  
Patient Signature

