



As part of your dental care at **Manos Dental**, clinical photographs may be taken before, during, and after treatment. These images are an essential part of diagnosis, treatment planning, documentation, and patient records.

#### **Clinical Use of Photos (Required)**

I understand and agree that photographs of my face, mouth, and teeth may be taken and used by **Manos Dental** for the following purposes:

- Diagnosis and treatment planning
- Progress documentation
- Communication with other dental/medical professionals
- Inclusion in my private dental records

☐ **I understand that these photos are necessary for my care and treatment and consent to their use for clinical purposes.**

#### **Marketing and Educational Use (Optional)**

With your permission, we would also like to use some of these photographs (excluding your full name) for educational and/or marketing purposes, including but not limited to:

- Office website and social media
- Print and digital marketing materials
- Lectures, seminars, or dental publications

☐ **I give permission** for **Manos Dental** to use my photos for marketing and educational purposes as described above.

☐ **I give permission** for **Manos Dental** to use my photos for marketing and educational purposes as described above **EXCLUDING images that include my full face or any other identifying features.**

☐ **I do NOT give permission** for my photos to be used for marketing or educational purposes.

**Consent and Acknowledgement:** I understand that I will not receive compensation for the use of these images. I understand that any images used publicly will not include my name or personal identifying information unless I give separate written consent. I understand that I may withdraw my marketing/photo release consent at any time by submitting a written request to the office.

**Signature of Patient (or Guardian)** \_\_\_\_\_ **Date** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**Relationship to Patient (if applicable):** \_\_\_\_\_