Consent for Photography

Consent for Photography

Patient First Name: Patient Last Name: DOB:

_____ _____ _____

I (the above-mentioned patient), authorize the doctor to take and/or reproduce photographs/video of my teeth or face for publications, presentations, patient testimonials, smile gallery and marketing materials to be used online, social media and/or website.

CONSENT

☐ I acknowledge I have read, and understand the above consent. I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. By signing below, I understand and agree that photographs and videos may be taken of me for educational and marketing purposes. I release the doctor from any liability resulting from this production. I waive my rights to any royalties, and fees and to inspect the finished production as well as advertising materials in conjunction with these photographs.

Signature of Patient, Parent, Guardian or Personal Representative:

Sign

Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient:

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