Elias N. Khoury, DMD
General and Cosmetic Dentist

DENTAL PATIENT RECORDING & TESTIMONIAL CONSENT FORM

Patient Name: _____
Date of Birth: _____
Purpose of Recording
Date: _____
I understand that ("Practice") may take photographs, audio recordings, and/or video recordings of me for the purpose of:

- Marketing and advertising
- Patient testimonials
- Social media posts
- Website content
- Educational and promotional materials

Consent & Authorization
I hereby authorize the Practice and its representatives to:

- Photograph, film, and/or record me before, during, or after treatment
- Use my likeness, voice, statements, and dental images
- Edit, reproduce, publish, or distribute these materials in print or digital format
- Use the recordings for advertising, testimonials, and promotional purposes

I understand that:

- My name (check one):

☐ May be used
☐ May NOT be used (initials only) _____

- I will not receive compensation for the use of these materials
- My care and treatment will not be affected by my decision to consent or decline
- Once published, the Practice cannot control how the materials are shared by others

Optional: Treatment Disclosure
☐ I consent to discussing my dental treatment as part of the testimonial
☐ I do NOT consent to discussing my dental treatment
Right to Withdraw
I understand I may withdraw this consent in writing at any time; however, materials already published may not be able to be removed.
HIPAA Authorization
I authorize the use and disclosure of my protected health information (including dental images) for the purposes listed above.
Patient Signature: _____
Printed Name: _____
Date: _____
Parent/Guardian (if minor): _____
Relationship: _____
Signature: _____
Practice Representative: _____
Date: _____

2515 S. Western Ave. #109 • San Pedro, CA 90732 • 310.832.2657 • 310.832.5164 Fax
seasmilesdental.com • frontdesk@seasmilesdental.com