

Photography Release

I, _____ ,

hereby authorize Dr. _____ or his assistants to take photographs, slides, and/or videos of my face, jaws, mouth and teeth.

I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for education purposes in study club meetings, lectures, seminars, demonstrations, and professional publications (journals, magazines).

I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential.

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

Signature _____

Date _____