Dental Photography Release

I, _____(Print Please), hereby authorize the team at Center for Dental Anesthesiology 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, will benefit my diagnosis, treatment planning, and laboratory communications and may be used for educational 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 acknowledge Center for Dental Anesthesiology's right to crop or otherwise treat the photographs at their discretion. I also acknowledge that Center for Dental Anesthesiology may choose to show my photographs and testimonials through the office website and/or other marketing channels. I acknowledge that the images can be downloaded by any computer user, which is beyond the control of Center for Dental Anesthesiology and I will hold them and any of their affiliated offices harmless from any such use or download. I do not expect compensation, financial or otherwise, for the use of these photographs.

I hereby freely and voluntarily consent to the use of my photographs and testimonial as stated above until I revoke this consent in writing.

Print Name _____

Signature _____

Guardian Name (if minor) _____

Date _____