Patient Photo Release Form

I hereby authorize Modern Dental Associates to take photographs, slides, and / or videos of my face, jaws 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 educational purposes in lectures, demonstrations, advertising (including website publication, social media, magazines, and newspapers, and professional publications (dental magazines and journals).

I further understand that if the photographs, slides, and / or videos are used in any publication or as part of a demonstration, my name (First Name Only) or other identifying information could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs.

Please initial:

____ I do not mind if my first name, face, and teeth are used in any of the above stated situations.

Exceptions:

____ I do not wish to have my first name shown or released

____ I only agree to have my face shown without any identifying features (e.g., eyes blurred out, etc.)

____ I do not wish to have my face shown at all

____ I only agree to have my teeth shown without any identifying features

____ I do not wish to have my photos used at all

Patient Name ________________________

Patient / Guardian Signature ________________________

Date__________

MDA
MODERN DENTAL ASSOCIATES