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## Patient Photo Release Form

I \_\_\_\_\_, hereby authorize Maplewood Dental Arts, or any of their assignees, to take photographs, slides, and videos of my teeth, jaws, and face. I understand that the photographs, slides, and videos will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures.

The content may also be used for advertising purposes (including website publication, Facebook posts, etc.). I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

Please initial one option:

\_\_\_\_\_ I do not mind if my photographs are used in any of the above-stated situations.

\_\_\_\_\_ I only agree to have my teeth shown without any identifying features.

\_\_\_\_\_ I decline the use of my photographs in any of the above-stated situations.

Name (please print): \_\_\_\_\_

Signed: \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian of a Minor:

Name/relationship to patient (please print): \_\_\_\_\_

Signed: \_\_\_\_\_ Date \_\_\_\_\_