

# YOUR FAMILY DENTAL

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## PHOTO & VIDEO CONSENT FORM

I recognize that my dentist and dental team are proud of the quality treatment that they will provide to me. I, hereby, provide my consent for dental photographs, videos or audio to be taken of me and/or my dependent(s) for dental treatment. I understand that my dental images may be used for various educational and marketing purposes.

By consenting to release my dental photographs, videos or audio, I understand that I will not receive payment from any party. Although these materials will be used without identifying information, I understand that it is possible that someone may recognize me. Refusal to consent to dental photographs or videos or audio will in no way affect the dental care that I will receive.

I authorize the use of my images (Please check / circle the YES or NO boxes below):

YES    NO For demonstration purposes including dental records and research, printed material, and patient education.

YES    NO For professional journal(s) or publications, lectures, seminars, and demonstrations.

YES    NO For the office website and social media such as: Facebook, Instagram, Twitter, etc.

YES    NO            As non-identifying photos only.

By signing below, I confirm that I understand this "Photo & Video Consent Form" completely and that my questions, if any, have been asked and answered.

Patient First & Last Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Signature: \_\_\_\_\_

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