Patient Photo Release

I hereby authorize Hymas Family Dental and/or any of their assignees 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, newspapers, magazines, phone books, television), 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 a 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 give permission for my first name, face, and teeth to be used in any of the above stated situations.

Exceptions:

__________ I do not wish to have my first name shown, or released.
__________ I do not wish to have my face shown.
__________ I only agree to have my teeth shown without any identifying features.
__________ I do not wish to have my photos used at all.

Name ____

X ____ Date signed: __________
Signature of patient or responsible person

Relationship to patient – Please Circle One **SELF** **PARENT** **GUARDIAN** **LEGAL REPRESENTATIVE**

If applicable:
Patient's Guardian or Representative's name: ___________________________ Phone: ____________________

Representative's relationship to patient: ___________________________

Representative's address:
____