ELKRIDGE
FAMILY DENTISTRY

Permission to Take Photographs, Slides and Videos

Patient Name_____

I do hereby authorize Elkridge Family Dentistry to take photographs, slides and/or videos of my face, jaws and the hard and soft tissues of my mouth.

I understand that these photographs, slides and/or videos will be a part of my permanent dental records.

I also understand that these photographs, slides and/or videos may be used for educational purposes in lectures and demonstrations. They may also be used in professional publications, marketing and Elkridge Family Dentistry's website. I understand that no personally identifiable image will be used unless there is additional informed and written consent.

I hereby agree, for no compensation, to release the rights to photographs, slides and/or videos taken by/for Elkridge Family Dentistry and I hereby authorize said use.

_____

Signature (if a minor, signature of parent or legal guardian)

_____

Date