PHOTO RELEASE FORM

I, _____ (patient's full name), grant _____ (name of practice) and any associate affiliated with the practice permission to take photos of my face, mouth, and teeth before, during, and after treatment. I authorize _____ (name of practice) to use these photographs for the purpose of dental records, marketing materials, and patient education. I understand that my photos will be used at my dentists' discretion in the office, on _____ (name of practice)'s website, or on any marketing materials. I do not expect compensation, financial or otherwise, for the use of these photographs.

I release _____ (name of practice) and its employees and legal representative from any and all claims, actions, and liability related to its use of said photographs.

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice. The authorization remains in effect unless written notice has been received by _____ (name of practice).

Patient Name _____ Date _____

Patient Signature _____