MODERN DENTISTRY
Comprehensive • Implant • Sedation

Photography Release

I _____, hereby authorize the doctor and staff of Modern Dentistry 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 for professional communications with other doctors, dental laboratories, or other professionals involved with my care.

I understand that these pictures may be used for educational purposes in lectures, demonstrations, advertising (including website publication, 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 or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

_____ _____

Signature Date