

**PATIENT PHOTO RELEASE FORM**

I hereby authorize Dr. Jeanne Martin 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, Facebook, 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 publications or as a part of a demonstration, my name (first name only) or other identifying information could be used of these photographs.

**Please Initial:**

**­­­­**\_\_\_\_I do not mind if my first name, face and teeth are 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

**PATIENT NAME: ­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GUARDIAN SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**