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Photography Release Form

I, ____ hereby authorize Dr. E. Morgan Scheiber, DMD and Dr. Rochelle Akradi, DMD, or their assistants and staff to take photographs, and/or videos of my face, jaws, mouth 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 study club meetings, lectures, seminars, demonstrations, and professional publications (journals, magazines).

I understand that these photographs may also be used in "before and after" sequences that the office may use on their website, in office displays, or in advertisements for the office.

I further understand that if the photographs, slides, and/or videos are used in any publication or as 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.

____

Patient Name Date

____

Patient Signature

This form is part of your permanent record