

I, (print name) \_\_\_\_\_, hereby authorize

Dental Wellness & Health 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, and professional publications.

I further understand that if the photographs, slides, and/or videos are used in any publication, or as part of a demonstration, all reasonable attempts will be made to conceal my identity.

\_\_\_\_\_  
Patient's Signature (Or Guardian if a Minor)

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Witness's Signature

\_\_\_\_\_  
Date