Photography Release Form

I _____the undersigned, do hereby authorize and consent to the use of photographs/x-rays of me taken by [insert dental office name]. I grant them permission to reproduce, print and publish photographs taken of me in a professional publication or in the form of prints, film or slides in connection with articles and lectures dealing with the jaw or dental disorders. I specifically waive any claim for invasion of my personal privacy which might accrue to me on account of the use of such pictures without my express consent in each instance.

I do consent to the use of my photographs or images for marketing materials including website and patient education for SOUTH COUNTY DENTAL GROUP only. I further understand that if the photographs and/or images are used, my name or similar identifying information will not be used.

No full face or comparable photos will be used without your express written authorization.

I further acknowledge that my participation is voluntary and that I will not receive any compensation, financial or otherwise, with respect to the taking, use or publication of these photographs for any dental office publications. I acknowledge and agree that publication of photographs confers no rights of ownership or royalties whatsoever.

Patient's Name: _____

Patient or Guardian Signature: _____

Dentist Signature: _____Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

SOUTH COUNTY DENTAL GROUP
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