Photo Consent Form

Patient Name: _____ DOB: _____

I consent for photographs to be taken of me by Smiles of Temecula to be used in my medical record, for educational and training purposes, and for marketing material, including websites and printed materials for patient education.

By consenting to these photographs, I understand that I will not receive payment from any party. I understand that although these photographs will be used without identifying information, including my name, that it is possible that someone may recognize me.

Refusing to consent to these photographs will not change the care that I receive. If I wish to withdraw my consent at any time, I may do so with a written request.

I authorize the use of these images: (Please initial indicating YES or NO below)

____YES ____ NO For demonstration purpose including an office photo album for patient treatments

____YES ____NO On our website for prospective patients/success stories

____YES ____NO In print advertisements and/or professional journals

By signing this form below, I confirm that this consent form has been explained to be in terms in which I understand.

_____ _____

Patient Name Printed Date

_____

Patient Signature