Patient Photo and Video Release Form

I, _____, hereby authorize Hoffman Dental Care to take photographs and videos of my teeth, jaws, and face. I understand that the photographs and videos may be used as a record of my care and may be used for communication with other health care professionals and educational publications (dental journals). The content may also be used for marketing purposes, including website publication and on social media platforms, etc.

I further understand that if the photographs or videos are used in any publication or as a part of demonstration, my identifying information (first name and first initial of last name) may be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs and videos. If I wish to revoke this consent, I may do so in writing.

If declining this consent, leave blank.

Please initial one option:

_____ I consent to the use of my photographs or videos to be used in any of the above stated situations.

_____ I only consent to have my teeth shown without any identifying features.

Patient Name_____ Date_____

Parent/
Guardian Signature_____ Date_____

Witness_____ Date_____