Consent for Social Media

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Patient First Name: Patient Last Name: DOB:

_____ _____ _____

I (the above-mentioned patient), authorize the doctor to take and/or reproduce photographs/video of my teeth or face for publications, presentations, patient testimonials, smile gallery and marketing materials to be used online, social media and/or website.

Mark the following as:

- ☐ I consent for the full portfolio use of my photographs.
- ☐ I consent for ONLY the use of the diagnostic photographs. (Not including the profile, front face or any recognition of myself/child)
- ☐ I do NOT consent for the use of my images.

CONSENT

- ☐ I acknowledge I have read, and understand the above consent. I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. By signing below, I understand and agree that photographs and videos may be taken of me for educational and marketing purposes. I release the doctor from any liability resulting from this production. I waive my rights to any royalties, and fees and to inspect the finished production as well as advertising materials in conjunction with these photographs.

Signature of Patient, Parent, Guardian or Personal Representative:

Sign

Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient:

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