

Patient Photo and Video Release

Watterson Dentistry

1030 Laurence Ave

Jackson, MI 49202

517-782-1467

I hereby authorize Watterson Dentistry or any of their assignees to take photographs, slides, and videos of my office visits, consultations, teeth, jaws, and face. I understand that the photographs, slides, and videos will be used as a record of my care, internal training and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, Facebook posts, etc.) I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing. If declining this consent, leave blank.

Please initial on option:

_____ I do not mind if my photographs or videos are used in any of the above-stated situations.

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

Signed

Date
