ALICIA L. DWYER D.D.S. P.A.
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972-556-2414

Patient Photo/Video Release Form

I _____, hereby authorize Alicia L. Dwyer D.D.S. P.A., or any of their assignees to take photographs, slides and videos of my teeth, jaws, and face. I understand that the photographs, slides, and videos will be used as a record of my care , 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 post, etc.)

I further understand that if photographs, slides and videos are used in any publication or as part of 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.
Please initial one option:

____ I do not mind if my photographs are used in any of the above stated situations.
____ I only agree to have my teeth shown without any identifying features.
____ I only agree profile picture for my chart and doctor use only.

_____

Signature Date