Consent to Dental Photography

I, ______________________________ (**Patient name**), hereby authorize Hutchens Family Dentistry to take photographs and/or videos of my face, jaws and teeth before, during and after treatment.

I consent to allow the photographs to be used for the following **(Please check):**

___ Dental Records, dental research, and dental education including study clubs, lectures, demonstrations, professional publications

___ Marketing material including websites, printed materials, and patient education

___ I do **not** consent to photos.

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature: ____ Date:____________

Patient/Parent/Guardian (if minor)