Print Form

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PATIENT PHOTO RELEASE FORM

I _____, hereby authorize Dr. Byron R. Rome and/or any of his assignees to take photographs, slides, and/or videos of my face, jaws, and teeth.

I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals).

I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name (First Name Only) or other identifying information could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs.

Please initial:

_____ I do not mind if my first name, face, and teeth are used in any of the above stated situations.

Exceptions:

_____ I do not wish to have my First Name shown, or released.

_____ I do not wish to have my face shown.

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

_____ I do not wish to have my photos used at all.

Printed Patient Name	Signature of Patient or Guardian	Date