

CONSENT TO DENTAL PHOTOGRAPHY

I, _____ (Patient), authorize Dr. Carol Chang DDS, FAGD, MAGD, 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:

- Dental Records
- Dental Research
- Marketing material, including websites and printed materials, patient education
- Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books

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.

Check here if you do not want your full face shot used for any of the above purposes

Patient Printed Name _____

Patient/Guardian Signature _____ Date _____

Witness Signature _____ Date _____