AUTHORIZATION FOR DENTAL PHOTO USE

919-859-1000 | email to: team@dentistrybydesignofcary.com

DENTISTRY by DESIGN of Cary
Evidence-Based Medicine

Name: _____ **Date of Birth:** _____

During the regular course of dental care at Dentistry by Design, we will make radiographs, photographs, and study models.

We will use these items in order to share our findings and our diagnosis with you. Additionally, they are used in documenting the progress of your dental health.

All professionals continue to learn and grow better at everything they do by sharing their learning experience with their patients and colleagues.

This information is never personal, and is limited to radiographs, photographs, study models, and the history of the situation as well as our process to make it better.

Current and potentially new patients will benefit from the opportunity to see what may be possible when they work together with us.

We are proud of our results, and when there are particularly remarkable smiles or interesting situations, we would like to share them in various manners, including print media, photo albums, television ads, on digital media and on our web-page.

As you know or will learn, we treat the whole person and not just their teeth. Teeth without the face or the person does not convey the depth of great results. Therefore, in some instances, but not always, you may be recognizable in some of these images we will share with others.

Before we would consider sharing any of your information, we would like to ask your permission to allow us to do only what you feel comfortable in doing to help us help others.

By initialing and signing below, you can indicate how we use your information. In this way, you are authorizing us and releasing us from any liability resulting from the use of such images. Your authorization will in no way affect the quality of your results in our office. We do our best to provide exceptional dentistry to all patients.

I authorize the following use of my images MARKED with my initials on the left.

_____ I authorize the use of images of my teeth where my face may be identifiable.
_____ I authorize the use of images of my teeth where my face is not identifiable.
_____ I authorize the use of images of my teeth and face for my diagnosis and treatment only.

This authorization will remain in effect until canceled in writing. Any future cancellation will not affect the usability of images that have already been released.

I have read and understand this form and have indicated my choice above.

Printed Name of the PERSON COMPLETING FORM: _____

If other than patient, indicate relationship to patient: _____

Date: _____ Signature: _____

Date: _____ Witness: _____