GENERAL MEDIA RELEASE FORM

In connection with dental services and/or treatment being rendered, I give permission for photographs/videos to be taken of me, with the following stipulations:

1. The photographs/videos may be taken by my dentist, a professional photographer, or a technician under their direction.

2. The photographs/videos may be used for social media, medical records, or as educational materials as deemed appropriate by my dentist.

3. I will not be identified by name other than for medical records purposes

Please Initial all that apply:

I _____ hereby understand and give consent for my photos/videos to be used for marketing purposes, including on the Practice website and Social Media platforms. I understand that my identity will not be disclosed without further consent. I understand that I might be identified by first name only and that my privacy will be protected as per HIPAA regulations.

I _____ DO NOT consent to have pictures/videos taken for social media platforms and or for website use.

Please Sign