River Walk
FAMILY DENTAL

Patient Photo Release Form

I_____, hereby authorize River Walk Family Dental and any of their assignees to take photographs of my teeth, jaws, and face. I understand that the photographs will be used as a record of my care, and may be used for communication with other health care professionals, educational publications and educational lectures
The content may also be used for advertising purposes including websites, facebook posts and printed materials.

I further understand that if the photographs are used, my name or other identifying information's will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

If declining this consent, leave blank.

Patient Signature: _____ Date: _____

Responsible Party (if patient is a minor): _____