CONSENT FORM FOR PHOTOGRAPHY

I, ……(Patient), authorise

Dr……(Dentist), to take

Tick all that apply:

☐ **Photographs**

☐ **Videos**

of my,

☐ **Whole Face**

☐ **Lower Face and teeth**

before, during and after treatment.

I consent to allow the photographs to be used for the following:

☐ Dental records, dental research, dental education including lectures, seminars, demonstrations, professional publications such as journals or textbooks.

☐ Marketing material, including websites, social media (e.g Instagram, Facebook) and printed materials, patient education

- I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.
- I understand that once the material has been used on social media it cannot be undone and its use will be out of my control.
- I do not expect compensation, financial or otherwise, for the use of these photographs.

SIGN…… DATE……

PRINT FULL NAME……

DIAN Club.