Patient Photo Release Form

I _____, herby authorize Megan M. Raynor, DMD or Pamela A. Linker, DDS, or any of their assignees to take photographs, slides, and videos of my teeth, jaws and face. I understand that the photographs, slides and videos will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals) and educational lectures. The content may also be used for advertising purposes (including website publication, Facebook posts, etc.)

I further understand that if the photographs, slides, and videos are used in any publication or as part of a demonstration, my identifying information (first name only) could be used unless stated differently below. 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.

Please initial ONE option:

____ I do not mind if my photographs are used in any of the above stated situations.

____ I only agree to have my teeth shown without any identifying features.

Signed _____Date _____

Patient Rights

I have the right to revoke this authorization at any time. I may inspect or copy the protected health information to be disclosed as described in this document. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward. Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization will remain in effect until revoked by the patient.