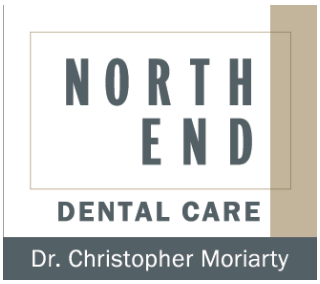

Patient Photo Release Form

I _____, hereby authorize, North End Dental Care, 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 a 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.

Name (please print): _____

Signed:_____Date_____

Parent or Guardian of a Minor:

Signed:_____Date_____