

Allyson Bauch- Friedrich, D.D.S, PLLC

Consent to Dental Photography

I, _____ (Patient), authorize Dr. Allyson Bauch-Friedrich D.D.S, or staff to take photographs, and/or videos of my face, jaws 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 books*
- *Marketing material, including websites, social media, printed materials, and 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 do not expect compensation, financial or otherwise, for the use of these photographs.

Check here if you do not want your full face shot used for any of the above purposes

Patient Name: _____

Signature (Patient/Guardian) _____

Witness: _____

Date: _____