Dental Solutions
a whole health approach

Patient Photo Release Form

I hereby authorize Dr. Wall and/or any of his assignees to take photographs, slides, and/or videos of my face, jaws, and teeth.

I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals).

I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name (*First Name Only*) or other identifying information could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs.

Please initial:
_____I do not mind if my first name, face, and teeth are used in any of the above stated situations. Exceptions:
_____I do not wish to have my First Name shown, or released.
_____I do not wish to have my face shown.
_____I only agree to have my teeth shown without any identifying features.
_____I do not wish to have my photos used at all.

Patient Name
_____

Patient/Guardian
Signature_____

Date_____

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