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 do not expect compensation, financial or otherwise, for the use of these photographs.

Patient Name
_____

Patient/Guardian
Signature_____

Date_____

235 S. 400 E. Bountiful, UT 84010 T: 801.298.1812 F: 801.298.4043
www.utahdentalsolutions.com mail@utahdentalsolutions.com