WILLOWBROOK
DENTAL ASSOCIATES

Photography Release

I, _____,

hereby authorize representatives of Willowbrook Dental Associates to take photographs, slides, and/or videos of my face, jaws, mouth, 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 marketing and educational purposes. They may be used in continuing education meetings, lectures, seminars, demonstrations, professional publications (journals, magazines), practice website and pamphlets.

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 or other identifying information will be kept confidential.

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

Signature_____

Date_____

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