CONSENT TO DENTAL PHOTOGRAPHY

I, _____ (Patient), authorize Dr. Marjan Salari, DDS, MS or her associates, 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 and printed materials, 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
☐ Check here if you wish to decline use of any photos for any of the above purposes

Patient or Parent/Guardian Signature: _____

Date:_____

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