**PHOTOGRAPHIC AUTHORIZATION & RELEASE**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Patient), authorize Elite Dental Group , and/or their representative(s) to take photographs, slides, or video of me, my face, jaws and teeth, for any procedure that I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ may undergo to be used before during and /or after treatment.

I consent to allow the photographs to be used for the following:

* Office Photo Album
* Office Seminars
* On our website
* Printed Advertisements and /or Patient Education Materials
* Any and all other forms of advertisement or Media presentation used by Elite Dental Group and or their representative(s)

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential. However, I also understand that in some circumstances the photographs, slides, videotapes or printed materials may display features that identify me.

I do not expect compensation, financial or otherwise, for the use of these photographs and or any of the above mentioned sources.

By signing below you are authorizing Elite Dental and/or their representative(s) to all mentioned above within this Authorization & Release Form.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_