Photographic Release

I _____, hereby authorize Dr. Meghna Dassani to take photographs, slides, and/or video 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, etc.) and professional publications (dental magazines and journals). I do not expect compensation, financial or otherwise, for the use of the photographs, slides, or videos.

_____ _____

Patient Signature Date

_____ _____

Witness Date