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Photography Release

I, _____, hereby authorize Dr. Janée Atkinson and/or her associates or staff members 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 treatment, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication), social media (office Facebook page), and professional publications (dental magazines and journals).

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.

_____ _____

Patient's Signature Date