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Photo and Video Release Form

I hereby authorize the staff of Solon Family Dental to take photographs/videos of my teeth, mouth, jaws and face before, during, and after treatment. I consent to allow the photographs and videos to be used for the following professional purposes:

- Insurance reimbursement
- Dental records
- Dental research
- Dental education for myself and others, including but not limited to training purposes, lectures, presentations, publications, etc.
- Marketing materials and advertisements, including use on social media, websites, printed materials and in-office demonstrations
- Communication with other healthcare professionals

I further understand that if the photographs/videos are used, my name and other identifying information will be kept confidential; I may be identified by my initials or my first name only. I do not expect compensation, financial or otherwise, for the use of these photographs/videos. If I wish to revoke this consent, I must do so in writing.

_____ I authorize this photo/video release form to apply to all photographs and videos taken of the specified patient at Solon Family Dental.

We understand that some patients would prefer their photographs to be non-identifying. If you would prefer to not have full-face photos shared (meaning ONLY anonymous photos of your teeth, jaw and/or mouth), please check below:

___ I do not want my full-face photograph/video used for any of the above purposes. (This means that ONLY photos/videos of your teeth, jaw and/or mouth will be used.)

Patient Full Name: _____

Signature of Patient or Responsible Party: _____

Today's Date: _____