dhs

Dental Health Specialists

Photography/Imaging Consent Form

I consent for medical imaging (photo, video, radiographic images and/or audio) to be made of myself or my child (or for whom I am the legal guardian). I understand that the information from my medical records may be used for purposes of teaching, publication, marketing, advertising, and media (including websites, printed materials, news reporting, documentary films, commercials, television or film, social media).

By consenting to this, I understand that I will not receive payment from any party. Refusal to consent to photographs, video, and/or audio recording will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future, I may contact Dental Health Specialists.

By signing this form below, I confirm that this consent form has been explained to me in terms which I understand – that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me.

Patient Name: _____

Signature: _____ Date: _____

Relationship to patient (if patient is a minor): _____