

CHERRY FAMILY DENTISTRY

Photograph Release Form

I hereby give my consent for CHERRY FAMILY DENTISTRY to take photographs of my face, jaw and teeth. I understand that some of these images may be used by laboratories for fabrication of crowns, veneers, bridges or dentures and these images will become part of the patient record.

I give consent for to use these images for:

Use within the dental practice	Yes	No
<i>Promote the dental practice through:</i>		
Print	Yes	No
Brochures	Yes	No
Practice website	Yes	No

I hereby release and discharge CHERRY FAMILY DENTISTRY from any and all claims and demands arising out of or in connection with using these images, including all claims for libel and invasion of privacy.

I understand I may have a copy of this authorization.

Patient/Guardian Name: _____

Please Print

Patient/Guardian Signature: _____