Authorization for Use of Dental Photos

I, _____, hereby release the use of any photos taken by Bellevue Dental Excellence for educational and diagnostic purposes. I understand that my identity will be held confidential.

O I release all photos, including those in which my face is visible.

O I release photos depicting TEETH ONLY.

_____ _____

Patient Signature Printed Name

DECLINE the Use of my Dental Photos

I, _____, DO NOT release the use of any photos taken by Bellevue Dental Excellence for any use.

_____ _____

Patient Signature Printed Name

Man Sunwoo, DMD.

14700 NE 8th St. Suite 210. Bellevue, WA 98007. (425)378.1600. office@bellevuedentalexcellence.com