# PHOTOGRAPHIC RELEASE AND CONSENT

 In consideration that my doing so will further knowledge and education in the field of dentistry, I hereby consent and agree that Dr. \_\_\_\_\_\_\_\_\_\_\_, or any person authorized by him, may use, reproduce or otherwise publish photographic illustrations of me and of any before and after illustrations, of any dental work which I receive, in any lectures or publications which Dr. \_\_\_\_\_\_\_\_\_\_ may give or participate in, for purposes of patient education and for use for demonstration purposes in Dr. \_\_\_\_\_\_\_\_ office. Such use, including use in any advertising and promotion, shall be without compensation to me.

I hereby release Dr. \_\_\_\_\_\_\_\_\_\_ and any third party, who may make use of such photographic illustrations, as contemplated by this release and consent, from any and all claims arising out of or in conjunction with such use.

I represent that I am eighteen (18) years of age or over and have read and understood the foregoing and I agree to be bound thereby.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Print: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_