CONSENT FOR DENTAL PHOTOGRAPHY

I, ____, (patient), authorize

Kaufman & Kaufman Smile Design Studio, LLC, to take photographs, and/or videos of my face, jaw and teeth: before, during and after treatment.

I consent to allow the photographs be used for the following:

- Inclusion in my dental records
- Any purpose of illustration; lectures, seminars, professional publications such as journals and books deemed appropriate by any authorized agent of this practice and/or laboratory ceramist.
- Law enforcement request
- Marketing material, including websites, social media, printed material and patient education.

I further understand that if the photography and /or videos are used, my name or other further identification will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

____ ______/_______/______

Signature (patient or guardian) Date