Swiss Biologic Dentistry

PHOTOGRAPH AUTHORIZATION FORM

Patient Name: _____ DOB: _____

Use of Photographs for Medical and Diagnostic Purposes

initials

☐ I understand that Swiss Biologic Dentistry, from time to time, must take photographs of my, or my child's teeth, jaw, and/or face for **any and all diagnostic purposes or treatments.** I understand that photographs may be necessary to fully perform the dental services I have requested from this office. Photographs used in this context shall only be used by those professionals and/or employees who provide care or necessary ancillary dental services. Any photos so used shall become a part of my, or my child's permanent patient record.

Additional Photograph Use Authorizations

This office uses photographs for both marketing and educational purposes. Being able to use real photographs of our work is important to educating patients about our procedures and outcomes. We believe it is better to show our actual results instead of just talking about them. We ask that you give us the following authorizations, but your treatment **WILL IN NO WAY BE AFFECTED** if you choose not to.

CHOOSE ONE OPTION PLEASE:

☐ I consent to the use of these images to promote the dental practice through various media, including (but not limited to) print and online advertising.

☐ I consent to the use of images within the dental practice's office to only be seen by patients and potential patients.

☐ I do not want my photos used for promotional purposes.

☐ For those who authorized the use of their photographs, by consenting to the use of these photographs as described above, I understand that I will not receive compensation, financial or otherwise, from Swiss Biologic Dentistry. I hereby release and discharge Swiss Biologic Dentistry from any and all claims and demands arising out of or in connection with the use of my photographs, or other information provided by me, including any and all claims for libel and invasion of privacy.

Patient or Parent/Guardian Signature: _____ **Date:** _____

Patient or Parent/Guardian Name: _____ **Date:** _____

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