VACA & KIRBY DENTAL

CARING FOR YOU & YOUR SMILE

CLIENT PHOTO RELEASE FORM

I, _____, hereby authorize Vaca & Kirby Dental Group to take photographs, x-rays, intra-oral, slides and /or videos of my facial area, jaws, teeth or anything in reference to my dental treatment.

I understand that these diagnostic tools will be used as a record of my care and may be used for educational purposes in lectures, demonstrations and advertising. Their use may include, but are not limited to, website publication, newspapers, magazines, phone books, television and professional (dental magazines and journals), videos and social media.

I also understand that if the photographs, x-rays, intra-oral, slides and/or videos of my facial area, jaws, teeth or anything in reference to my dental treatment are used in any type of marketing publication or as part of any presentation or demonstration, that my name or other identifying information may be used unless otherwise stated below. I do not expect compensation, financial or otherwise, for the use of photographs. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

PLEASE INITIAL:

____ I do not mind if my name and face are used in any of the above mentioned situations.

EXCEPTIONS:

____ I do not wish to have my name shown or released.

____ I do not wish to have my face shown.

Signature: _____ Date: _____

If patient is a minor:
Parent/Legal Guardian: _____ Date: _____

Signature: _____ Date: _____

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