



Photo Consent Form

I _____, hereby give Electric City Dentistry permission to photograph, film, videotape myself whole or in part. I also consent to the use of these images, still and/or video, for promotional and educational purposes, including but not limited to newspapers, magazines, television, electronic and social media (Instagram, Facebook, Snapchat) in perpetuity. I understand that I will not be identified by name.

I _____, consent to the use of my dental diagnosis, written and in images, to be used by Electric City Dentistry through promotional and educational purposes, including but not limited to newspapers, magazines, television, electronic and social media (Instagram, Facebook, Snapchat) in perpetuity.

Authorization may be revoked in writing by me, _____, at any time except to the extent that action has been taken in reliance on this authorization.

NAME (PARENT OR LEGAL GUARDIAN)

SIGNATURE

RELATIONSHIP (IF SIGNING FOR MINOR)

DATE