D.C. Dental Care, P.L.L.C.
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Dr. Dana Culda, DMD



Patient Photo Release Form

I _____, hereby authorize DC Dental Care PLLC, or any of their assignees to take photographs, slides, and videos of my teeth, jaw and face. I understand that the photographs, slides, and videos will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, Facebook, Tweeter, or any other social media, etc.)

I further understand that if the photographs, slides and videos are used in any publication or as part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.

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

- Dental Record
- Dental Research
- Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books
- Marketing material, including websites, any social media, printed materials, and patient education

I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

Please initial one option:

_____ I do not mind if my photographs are used in any of the above situations.

_____ I only agree to have my teeth shown without any identifying features.

_____ I do not agree to have my photos, slides, or videos used for any publication.

_____ _____ _____

Print Name Signature Date