DENTAL ASSOCIATES OF FLORIDA, P.A.

PHOTO & VIDEO
CONSENT & RELEASE FORM

I recognize that my dentist and team are proud of the quality treatment that they will provide to me. I, hereby, provide my consent for medical photographs, videos or audio to be taken of me and/or the procedure being done by my dentist and the dental team. I understand that the information may be used for the following purposes:

- dental records and research
- purposes of dental education including lectures, seminars, demonstrations, professional publications such as journals or textbooks
- dental office marketing materials and advertisements including websites, social media platforms and printed materials and patient education

By consenting to release my dental photographs and/or audio/video, I understand that I will not receive payment from any party. Although these photographs, videos or audio will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. Refusal to consent to photographs or videos will in no way affect the dental care that I will receive.

I authorize the use of these images (Please check the YES or NO boxes below):

☐ YES ☐ NO For demonstration purposes including an office photo album
☐ YES ☐ NO For our website, professional journal and/or advertisement purposes or social media accounts (examples: Facebook, Instagram, Twitter, etc.).
☐ YES ☐ NO I give my consent for ONLY non-identifying photos taken.

By signing below, I confirm that I understand this consent and release form completely and that any questions I had have been asked and answered.

Printed Patient Name:	Date:
Patient Signature:	