MAVERICK SMILES
PEDIATRIC DENTISTRY
SMILE BIG. STAND OUT. BE YOU.

Patient Photo Release Form

_____
Patient Name

I hereby authorize Maverick Smiles Pediatric Dentistry to take photographic, slide, and video images of my teeth, jaws, and face. I understand that the images 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. These images may also be used for advertising purposes (including website publication, Facebook post, etc.).

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

If declining to the release of photos in accordance with the terms above, please initial the option below:

_____ I do not agree to the use of photographs in any of the above stated situations.

If consenting to the release of photos in accordance with the terms above, please initial the option below:

_____ I agree to the use of photographs in any of the above stated situations.

_____ _____
Patient Name Date

_____
Legal Guardian Signature