

**CONSENT TO USE PHOTOGRAPHS**

By my signature below, I hereby give my consent for \_\_\_\_\_,  
D.D.S., to take photographs of me for use in medical or dental teaching and writing.

These photographs may be published in medical books, journals or CD-ROMS or  
displayed on medical or dental Internet sites to advance medical knowledge, practice or  
education. These photographs may / may not (circle one) be used for advertising.

I am over 18 years of age.

\_\_\_\_\_  
(Patient Signature)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Date)

Employee taking pictures, sign here: \_\_\_\_\_

**CONSENT OF PARENT / GUARDIAN TO USE PHOTOGRAPH OF CHILDREN**

(To be obtained when subject is under 18 years of age)

I am the parent/guardian of \_\_\_\_\_, and by my signature  
below, I hereby give my consent to \_\_\_\_\_, D.D.S., to take  
photographs of him/her for use in medical or dental teaching and writing.

These photographs may be published in medical books, journals or CD-ROMS or  
displayed on medical or dental Internet sites to advance medical knowledge, practice or  
education.

\_\_\_\_\_  
(Patient Signature)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Date)

Employee taking pictures, sign here: \_\_\_\_\_