

**WAIVER AND CONSENT**

I, \_\_\_\_\_ the undersigned, do hereby authorize and consent to the use of certain photographs/x-rays of me taken by \_\_\_\_\_. I hereby grant them permission to reproduce, publish, print, use and distribute copies of such photographs/x-rays either in an official medical publication or in the form of prints, slides or film for use in connection with articles and lectures dealing with jaw or dental disorders. I specifically waive any claim for invasion of my personal privacy, which might accrue to me on account of the use of such pictures without my express consent in each instance.

**NO FULL-FACE OR IDENTIFYING PHOTOS WILL BE USED WITHOUT YOUR EXPRESSED WRITTEN CONSENT FOR EACH ONE.**

Polaroid photography taken during treatment are used by our laboratories for cosmetic purposes for the fabrication of your crowns, bridges or dentures and are a part of your permanent dental record.

\_\_\_\_\_  
Patient's Signature and/or Guardian

\_\_\_\_\_  
Patient's Address

\_\_\_\_\_  
Date

Please initial one of the following:

\_\_\_\_\_ I do not consent to the use of slides or photography for use in dental education or publications.

\_\_\_\_\_ I do consent to the use of slides or photographs for use in dental education or publications.

\_\_\_\_\_ I do consent to the use of slides or photography EXCEPT full face or identifying views.