PATIENT PHOTOGRAPHY RELEASE FORM

Patient Name: _____
Last First MI Maiden or Other

Date of birth: _____/_____/_____ Phone Number: _____

Address: _____City: _____State: _____Zip:_____

I grant Keene Family Dental permission to take and use photographs and digital images of me for the purpose of:

- ❑ **Teaching (i.e. Educational materials)**
- ❑ **Marketing (i.e. Web site, social media, brochures, etc.)**
- ❑ **Other: _____**

This request and authorization applies to photography or digital images taken on or after:

_____
Date(s) of image capture

I understand that once my photograph(s) or digital image(s) have been released, Keene Family Dental may no longer have control over them, and federal or state privacy laws may no longer protect the information that was released.

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already used my photograph(s) or digital image(s) prior to me canceling this authorization, which would not prohibit any release done prior to the date of cancelation.

To cancel this agreement, I must write a letter to the doctor or practice advising of my wish to cancel my authorization to release photograph(s) or digital image(s) taken of me by this practice. I (or my authorized representative) must sign and date the letter.

_____ _____
Patient Signature/Legal representative Date

_____
Relationship of legal representative

Keene Family Dental