Consent to Dental Photography

I, ___________________________________(Patient Name), authorize:

Dr. Brent Cline, DDS and authorized members of the Oxford Dental Care staff to take photographs and/or videos of my face, mouth, teeth, and jaws, before and after treatment.

I consent to allow the photographs to be used for the following professional purposes:

- Dental Records
- Dental Research
- Dental Education, for myself and others, including but not limited to training purposes, lectures, presentations, etc.
- Marketing material and advertisements, including limited use on social media, websites, printed materials, and in-office demonstrations

I further understand that if the photographs and/or videos are used, my name and other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of my photographs and/or videos.

I understand that the practice cannot condition the treatment I do or do not receive based on whether or not I sign this authorization.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

☐ "I do not want my **full-face photograph** used for any of the above purposes."
(This means that only photos of your teeth, jaws, and mouth will be used.)

☐ "I wish to have a copy of this signed form to take home for my own keeping."

Patient/Guardian Signature ____ Date ___________