Patient Photo Release Form

I,_____, hereby authorize Dr. Todd G. Yoshino or any of his assignees to take photographs, slides and/or videos of my face, jaws and teeth.

I understand that the photographs, slides and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books) and professional publications (dental magazines and journals).

I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will not be used. I do not expect compensation, financial or otherwise, for the use of these records.

Please initial one of the following:

_____I do not mind if my face is used in any of the above stated situations.

_____I do not wish to have my face shown.

_____I do not want any photographs, slides or videos used for publication purposes.

Signed_____Date_____

Print name if parent or guardian_____