

Max Teja D.D. S.
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Photo/Video Release Form

I _____, hereby authorize Dr. Teja or his staff to take photographs, slides, and / or videos of my face, jaws, and teeth. If patient is a minor, I am authorizing for my child.

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, television), 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 be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

- ☐ I do not wish to have the photographs to be used for educational purposes in lectures, demonstration, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals).

Patient or Parent/Guardian Signature

Date

If Minor Print Patient's Name

Date