

WEST HARTFORD DENTAL GROUP PHOTO WAIVER AND CONSENT

I, _______ do hereby authorize and consent to the use of certain photographs/x-rays of me taken by WEST HARTFORD DENTAL GROUP. 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, social media and lectures dealing with jaw or dental disorders.

Patient's Signature and/or Guardian_____

Print Name

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 consent to the use of slides or photography **EXCEPT full face or identifying views**.