Photographic Release

In connection with dental services and treatment being rendered, I give permission for photographs to be taken of my body or parts thereof, with the following stipulations:

- The photographs will be made by a dentist, professional photographer, or assistant under his/her direction.
- Any recorded media will be used for dental records, but if in the judgement from a member of the professional staff that science or education would benefit by their use and presented in various forms such as slides, motion pictures, video tapes- they can also be used for that purpose. Photographs may be published separately or in connection with each other in professional journals or textbook.
- It is understood the patient will not be identified by name.
- Photographs may be modified or retouched by the professional staff.

I give my permission for Dr. Jeffery Rouse and Dr. Lisa Rouse to use photographs in professional publications and professional presentations until such time that Dr. Jeffrey Rouse and Dr. Lisa Rouse are no longer practicing dentistry or until I withdraw my permission, then this release shall be nulled.

Signature of Patient / Guardian: _____ Date: _____