JD

JUSTICE DENTAL WELLINGTON

535 Wellington Way, Suite 120

Lexington, KY40503

(859)278-2931

**CONSENT FOR PHOTO/IMAGE USE**

I, **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** the undersigned, hereby authorize the office of

**Justice Dental Wellington** to use the following images to be placed in a book of case samples, or for marketing or advertising purposes:

**Yes/No** Before and after pictures of my teeth

**Yes/No** Before and after pictures of my full face

**Yes/No/NA** Before and after pictures of the teeth and /or

 Full face of my minor child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Child’s Name

By signing this authorization, I waive any claims of breach of privacy pertaining to

the release of any photographic or digital images as checked above. I

acknowledge that I have received a copy of the privacy policies of this office.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature of Patient or Parent Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Printed Name of Patient or Parent Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Witness Signature (member of office staff) Date