deborahruprecht DDS
periodontics & implant specialty

CONSENT FOR CLINCAL PHOTOGRAPHY

I_____, hereby authorize Deborah Ruprecht, DDS or any of her assignees to take photographs, slides, and/or videos of my face, jaws, and teeth.

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

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

Please Initial:

_____ I authorize my name and face to be used in any of the settings stated above.

Exceptions:

_____ I do not wish to have my name shown or released.

_____ I do not wish to have my face shown.

_____ I agree to having only my teeth shown but not any facial features.

_____ _____

Signature of Patient or Parent/Guardian Date

_____

Printed Name of Patient