



Photograph Waiver and Consent Form

I, _____ the undersigned, do hereby authorize and consent to the use of photographs/x-rays of me taken by Tsar Dental, PC. 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 and lectures dealing with jaw or dental disorders or on our official website or in office smile library. I specifically waive any claim for invasion of my personal privacy, which might accrue to me on account of the use of such pictures without me expressing consent in each instance.

NO FULL-FACE OR IDENTIFYING PHOTOS WILL BE USED WITHOUT YOUR EXPRESSED WRITTEN CONSENT FOR EACH ONE.

Patient's Signature and/or Guardian

Patient's Address

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