

## PHOTO RELEASE FORM

Patient Name	Date
Subject: Photographs	
Permission to use photographs of	f patient :
diagnostic photographs of the abo	and its representatives and employees the right to take ove-named patient. I authorize Dental Implant Solutionz and
its assigns and transferees to copy	yright, use and publish the same in print and/or electronically.
	onz may use such photographs of me (without my name) and
	ustration of treatment plans, including for example such advertising, social media and web content.
I have read and understand the al	bove and am at least 18 years of age or the legal guardian of
the above-named patient.	Jove and an acteast 10 years of age of the legal guardian of
Signature:	Date:
Printed Name:	
Address:	
City, State, Zip:	