PHOTO RELEASE FORM

Patient Name_____Date_____

Subject: Photographs

Permission to use photographs of patient :_____

I Grant Dental Implant Solutionz and its representatives and employees the right to take diagnostic photographs of the above-named patient. I authorize Dental Implant Solutionz and its assigns and transferees to copyright, use and publish the same in print and/or electronically.

I agree that Dental Implant Solutionz may use such photographs of me (without my name) and for any lawful purpose and for illustration of treatment plans, including for example such purposes as publicity, illustration, advertising, social media and web content.

I have read and understand the above and am at least 18 years of age or the legal guardian of the above-named patient.

Signature:_____Date:_____

Printed Name:_____

Address:_____

City, State, Zip: _____