Photograph Waiver and Consent Form

I,_______________________________ the undersigned, do hereby authorize and consent to the use of photographs/x-rays of me taken by Boone Endodontics. 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 lecture dealing with endodontic treatment or on our official website. 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.

____
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 photography for use in dental education or publications.