O'CONNOR DENTAL CARE

Consent to Dental Photography

I, _____, give my consent to Dr. Emily K. O'Connor-Schwegman, D.M.D., and her staff to take photographs and/or videos of the head and neck areas, including the profile, face, teeth, smile, and intra-oral features pre-, during, and post-treatment of _____, for the purposes of internal office use in dental records or for use in treatment planning, education, publication in professional journals, and marketing/advertising materials including websites, social media, printed materials, and patient education.

I hereby waive any right that I may have to inspect or approve the finished product(s) and advertising copy to which the photographs may be applied.

I hereby release, discharge, and agree to save harmless Dr. Emily K. O'Connor-Schwegman D.M.D., and all persons acting under her permission or authority or those from whom they are acting from any liability by virtue of any blurring, distortion, alteration, optical illusion, or use in composite form, whether intentional or otherwise, that may occur or be produced in the taking of said photograph or in any subsequent processing thereof, as well as any publication thereof, including without any limitation any claims for libel or invasion of privacy.

I have a right to restrict the use of photographic images as indicated here _____.

I hereby warrant that I am of legal age and have the right to contract my own name, or I am not of legal age and my parent/legal guardian whose signature is witnessed below is executing this release. I/my guardian have/has read the above consent prior to its execution, and I/my guardian am/is fully familiar with the agreement.

Patient's Name (Print) _____ Date _____

Signature _____

Guardian (if under legal age) _____

Guardian Signature _____

Witness _____

Provider (Print) _____

Provider Signature _____

40 N. Grand Ave.
Suite 206
Fort Thomas, KY 41075

Phone: (859) 441-0033
Fax: (859) 441-4875

OCONNORSMILESNKY@GMAIL.COM