St. Mary's Dental

Permission to Take Photographs, Slides, and Videos

Patient Name: ______________________________________ Date: ______________________

I do hereby authorize Dr. Gina McCray and/or Dr. Kara McCray to take photographs, slides, and/or videos of my face, jaw, and the hard and soft tissue of my mouth.

I understand that these photographs, slides, or videos will be a part of my permanent dental record.

I understand that these photographs, slides, and videos may be used for educational purposes in lectures, demonstrations, and professional publications and I hereby authorize said use. If they are used for these purposes, I understand that every reasonable attempt shall be made to conceal my identity.

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Patient Signature Date

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Parent or Guardian Signature (if patient is a minor) Date

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Staff Member Witness Date