Dr. Matthew Cripe

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PATIENT PHOTO RELEASE FORM

I_____, hereby authorize Dr. Matthew Cripe or any of his employees to take x-rays, photographs, or videos of my face, teeth, and jaw. I understand that the photographs or videos will be used as a record of my care, and may be used for communication with other health care professionals, educational publications, dental journals, and educational lectures. The content may also be used for advertising purposes, including but not limited to website publication, facebook posts, instagram, or other social media sites.

I further understand that if x-rays, photographs, or videos are used in any publication or as part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these x-rays, photographs, or videos. Should I wish to revoke this consent, I understand that I should do so in writing.

Please initial one option:

_____ I consent to the use of my x-rays, photographs, or videos in any of the above stated situations.

_____ I only agree to have my teeth shown without any identifying features.

_____ I decline consent of any recordings of me to be shared without my expressed permission.

Signed _____ Date _____