



GREGORY A. WILLIAMS
DMD, PC

CONSENT TO DENTAL PHOTOGRAPHY

I, _____ authorize Dr. Gregory A. Williams DMD,

(print patient name)

to take photographs, and/or videos of my face, jaws and teeth, before, during and after treatment. I consent to allow the photographs to be used for the following:

- Dental Records
- Dental Research
- Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books
- Marketing material, including websites and printed materials, patient education

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Check here if you do not want your full face shot used for any of the above purposes.

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice. The authorization remains in effect unless written notice has been received by Dr Gregory A. Williams DMD, PC.



Signature

Date