



PHOTO RELEASE FORM

I, _____, grant ADAMS DENTAL and any associate
(patient's full name) (name of practice)
affiliated with the practice permission to take photos of my face, mouth, and teeth before,
during, and after treatment. I authorize ADAMS DENTAL to use these photographs
(name of practice)
for the purpose of dental records, marketing materials, and patient education. I understand that
my photos will be used at my dentists' discretion in the office, on ADAMS DENTAL's
(name of practice)
website, or on any marketing materials. I do not expect compensation, financial or otherwise, for
the use of these photographs.

I release ADAMS DENTAL and its employees and legal representative from any and
(name of practice)
all claims, actions, and liability related to its use of said photographs.

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 ADAMS DENTAL.
(name of practice)

Patient Name _____ Date _____

Patient Signature _____
