Steven A. Milman, D.D.S.
Specializing in Periodontics
and Dental Implants

Patient Photo Release

I, _____ (Patient), authorize Dr. Steven Milman and/or staff 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, slides, and / or videos are used in any publication or as a part of a demonstration, my name (First Name Only) or other identifying information could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs

☐ Check here if you do not wish to have your full face shot used for any of the above purposes

☐ Check here if you do not wish to have your First Name shown, or released

☐ Check here if you do not wish to have your photos used at all.

_____ _____

Signature of Patient Date

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