PHOTOGRAPH AUTHORIZATION

I hereby give my consent for **Dr. Whang** to take photographs, slides and/or videotape of _____ (patient's name) face, jaw, and teeth. I also grant permission to reproduce, print and/or publish these images for use in articles, lectures, or advertisements to promote cosmetic dentistry.

I understand that some of these images may be used by laboratories for fabrication of crowns, veneers, bridges, or dentures and these images will become part of my dental record.

I do not expect compensation, financial or otherwise for the use of these images.

Please Initial

_____ I consent to the use of my photographs, slides, and/or videotape for articles, lectures, marketing, advertising, and laboratory use.
_____ I consent to the use of my photographs, slides, and/or videotape ONLY for laboratory use.
_____ I DO NOT consent to the use of my photographs, slides, and/or videotape.

I understand that the information disclosed under this authorization may be subject to redisclosure and no longer protected by federal privacy regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. Finally, I understand that I may revoke this authorization in writing at any time by sending a letter to my dental care provider stating my revocation and the effective date, except to the extent that action has been taken in reliance on this authorization. Unless revoked by me, this authorization expires 10 years from the date I sign below.

_____ _____
Parent's or Legal Guardian's/Representative's Signature Date

_____ _____
Dentist's Signature Date

COPY OF THIS SIGNED DOCUMENT TO BE PLACED IN PATIENT'S CHART