Permission to take Photographs and Digital Images (X-Rays)

Patient Name

_____

_____ Date_____

I do hereby authorize Dr. Yasaman S. Roland to take photographs and digital images (x-rays) of my face, jaws and the hard and soft tissues of my mouth.

I understand that these photographs and digital images (x-rays) will be a part of my permanent dental records.

I also understand that these photographs and digital images (x-rays) may be used for educational purposes in lectures, demonstrations, and professional publications and I hereby authorize said use.

Patient Signature

_____

___ Date_____

Parent or guardian

_____

___ *Date*_____

(If patient is a minor)

Staff Member

_____

___ *Date*_____