I, _____ (patient) authorize Dr. Lisa Schulman and her staff members 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: (check boxes below)

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

- _____ Please check here if you do not want your full face shot used for any of the above purposes

_____ _____

Patient Signature Date