Ferrera Dental Care

PHOTO CONSENT AND RELEASE FORM

Patient Name: _____

I consent for photographs and/or video images to be taken of me by Ferrera Dental Associates, or a representative. I understand the images will be a part of my dental record and may be used for dental teaching or training or for marketing purposes (website, print, digital or social media).

By consenting to photographs and/or video images I understand I will not be compensated from any party. Although photographs and/or video images will be used without identifying information such as name, I understand it is possible someone may recognize me.

I further acknowledge that my participation is voluntary and agree that the use of any photographs and/or video images confers no rights of ownership or royalties whatsoever.

I authorize the use of photographs and/or video image: (please initial indicating YES or NO below)

_____ YES _____ NO For educational purposes (dental teaching or Training).

_____ YES _____NO For marketing and advertising purposes (Website, print, digital, or social media).

_____ YES _____NO At my request, my photographs and/or video Images will only be used as part of my dental record.

I hereby release Ferrera Dental Associates, its employees, and any third party involved in the creation of or publication of educational or marketing materials, from liability for any claims by me or any third party in connection with my participation.

By signing this form, I confirm understanding of this consent. If I wish to write my consent in the future, I may do so vis written request submitted to Ferrera Dental Associates, or by completion of a new form.

Patient Signature: _____ Date: _____

Robert A. Ferrera, D.D.S.

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