

PHOTO CONSENT FORM

I, _____, do hereby give my consent to David Slater, DDS, for the use of my dental photos, videos, and/or portrait as he sees fit for the advancement of cosmetic dentistry, educational viewing by other dental professionals, and in the promotion of cosmetic dentistry with or without my name, or with a fictitious name. I release and forever discharge him from any claims, demands or liabilities on account of such use.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

Doctor Signature _____ Date _____

I am the parent or guardian of the minor named above and have the legal authority to execute the above releases. I approve the foregoing and waive any rights in the premises.

Parent/Guardian Signature _____ Date _____

Witness Signature _____ Date _____

NOTICE OF RECEIPT OF PRIVACY PRACTICES

I, _____, have been offered a copy of Dr. Slater's privacy Practices Act.

_____ I have received a copy, read and understand the Privacy Act.

_____ I have read and understand the Privacy Act, but decline a copy.

_____ I decline to read or accept a copy of the Privacy Act.

Signature of Patient _____ Date _____