ASPIRE DENTAL CARE PLLC
ADVANCED FAMILY & COSMETIC DENTISTRY
Creating Beautiful Smiles, One Patient At A Time.

PHOTOGRAPH CONSENT

I, _____ give my consent to Dr.Sathvik Seshadri and his staff to take radiographs of dentition and/or photographs of the head and neck areas, including the profile, face, teeth, smile, and intraoral features, pre-, during, and post-treatment of _____for the purposes of internal office use in dental records or for use in treatment planning, education, publication in professional journals, and/or advertising. I understand that my identity will be blurred in most cases and that my personal information will be protected.

I hereby waive any right that I may have to inspect or approve the finished product(s) and advertising copy to which the photographs may be applied.

I hereby release, discharge, and agree to save harmless Dr. Sathvik Seshadri and all persons acting under his permission or authority or those for whom he is acting, from any liability by virtue of any blurring, distortion, alteration, optical illusion, or use in composite form, whether intentional or otherwise, that may occur or be produced in the taking of said photograph or in any subsequent processing thereof, as well as any publication thereof, including without any limitation any claims for libel or invasion of privacy.

I have a right to restrict the use of photographic images as indicated here _____.

I hereby warrant that I am of legal age and have the right to contract my own name, or I am not of legal age and my parent/legal guardian whose signature is witnessed below is executing this release. I/my guardian has read the above consent prior to its execution, and I/my guardian am/is fully familiar with the agreement.

Patient's Name (print): _____Date: _____

Signature: _____

Guardian (if under legal age): _____

Guardian Signature: _____

Witness: _____

Provider (print)_____