AUTHORIZATION FOR RELEASE OF PATIENT IMAGING

I, _____, understand that Dr. Saeid Mohtashami and/or associates or designees of 4M Dental Implant Center, may take photographs/video recordings and/or radiographic imaging before, during, and after my treatment.

I consent to allow the these to be used for the following unless I mark the boxes below stating limitations:

- Dental Records
- Dental Research
- Dental Education including lectures, seminars, demonstrations, and professional publications such as journals or books
- Marketing material including electronic, online, and printed matter, and patient education
- Quality assurance training

I further understand that if the photographs/video recordings and/or radiographic imaging 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.

☐ Check here if you consent to the above use of imaging with the restriction that we do not use imaging showing your full face.

☐ Check here if you DO NOT want ANY imaging used for any of the above purposes.

SIGNATURE OF PATIENT or LEGAL GUARDIAN DATE

RELATIONSHIP TO PATIENT DATE

SIGNATURE OF DOCTOR DATE

WITNESS DATE

4M DENTAL IMPLANT CENTER

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