PHOTOGRAPHY RELEASE CONSENT

I, (Full Name) _____, hereby give my explicit written consent to both (Dentist name) _____ and The Smiles Studio to use, republish and distribute information that identifies myself in writing, videos and photography for the purpose of printed or online patient information, advertising, marketing and education resources including but not limited to leaflets, websites, video sites e.g. YouTube, social media sites e.g. Facebook/Instagram, internet search engines e.g. Google for perpetual and/or commercial use.

I understand that both (Dentist Name) _____ and The Smiles Studio are not responsible for any unauthorised distribution and republication of the writings, videos or photographs by any third party, and there is no guarantee of removing all writings, videos or photography in the event that consent is withdrawn.

I consent to my personal data being collected and stored as per the Privacy Policy.

Patient Name

Patient Signature

Date

Dentist Name

Dentist Signature

Date
