Martin N. Gorman, DDS

Authorization and Consent To Use Photograph or Video Recording

Patient Name: _____

I, the undersigned, do hereby consent and agree that Martin Gorman, DDS and it's employees, and/ or agents have the right to take photographs, video, or digital recording of me and my dependent and to use these in any and all media, including educational materials, informational and conference presentations, social media, website, before/ after photos etc.

(Mark your choice below)

- ☐ **Yes-** Including full face
- ☐ **Yes-** But please exclude any recognizable facial features
- ☐ **No-** Photographs may only be used for medical records keeping and treatment planning only.

  I further consent that my name and identity may be revealed therein or by descriptive text or commentary.

(Mark your choice below)

- ☐ **Yes-** Use my name.
- ☐ **No-** I prefer to remain anonymous.

By signing this form below I confirm that this consent form has been explained to me in terms that I understand. I acknowledge that I have completely read and fully understand that above release and agree to be bound thereby. I understand that there will be no financial or other remuneration for the recording, either for initial or subsequent transmission or playback. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Name of Authorizing Individual: _____

Relationship to Patient:_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

If this release is obtained from a patient under the age of 18, then the signature of the parent or legal guardian is required.