WELLNESS
BIODENTISTRY

Patient Photo Release Form

I hereby authorize Dr. Baker and/or any of the associates or staff of Wellness BioDentistry to take photographs, slides, and/or videos of my face, jaws, and teeth.

I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, social media, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals).

I do not expect compensation, financial or otherwise, for the use of these photographs.

Patient Name

_____

Patient/Guardian
Signature_____

Date_____