FORT WAYNE
PROSTHODONTICS
Ryan Zimmerman DMD, FACP

CONSENT TO PHOTOGRAPHY

I, _______________________________(Patient), authorize

Dr. Ryan Zimmerman to take photographs and/or videos of my face, jaws, teeth, eyes before, during and after treatment.

I consent to allow the photographs to be used for the following:

- ☐ *Dental and Medical Records (Required)*
- ☐ *Dental and Medical Research*
- ☐ *Dental and Medical Education including lectures, seminars, demonstrations, professional publications such as journals or books*
- ☐ *Marketing material, including websites and printed materials, patient education.*

I further understand that if the photographs and/or videos 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 do not want your *full-face* shot used for any of the above purposes.

Signature (Patient): __________________________________ Date: ____________

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