

# Photo Consent Form

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

## Dear Parent / Patient

Star Dental LLC/12 Month Smiles LLC would like your permission to use pictures & video taken of you/ your child to showcase extraordinary before, during and after treatment on our website and our Facebook page.

## Declaration

I grant permission for photographs of me / my child to be used in the formats indicated above.

Name of Patient (minor): \_\_\_\_\_

Parent Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Patient Signature (if over 12 years) \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Thank you!

Star Dental LLC/12 Month Smiles LLC