emhardt
PEDIATRIC DENTISTRY

where smiles grow up

Photography / Social Media Consent / Release Form For News Media, Promotional Materials, Written Articles, Research and/or Photographs

I, _____ (Guardian of Patient), authorize Dr. Emhardt and the team of EPD, to take photographs, and/or videos of my child's face, jaws and teeth, before, during and after treatment. _____ (Childs Name)

_____ I consent to allow the photographs or videos to be used for the following: Dental records, dental research, dental education including lectures, seminars, demonstrations, professional publications such as journals or books.
INT

_____ Social media(Facebook, Instagram, Twitter, Google, Yelp) marketing material including websites and printed materials, patient education FULL FACE/ MOUTH
INT

_____ I refuse to share.
INT

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential, (other than if Full Face photographs are used) I do not expect compensation, financial or otherwise, for the use of these photographs.

Patient Name(s) _____

Parent/Guardian Signature _____ Date _____

John R. Emhardt DDS MSD
1818 North Riley Highway, Suite B | Shelbyville, IN 46176
317-699-6109 office | 317-825-0063 fax | emhardtpediatricdentistry.com

BOARD CERTIFIED