smiles DENTAL
AT RESTON TOWN CENTER

CONSENT FOR THE TAKING AND PUBLICATION OF PHOTOGRAPHS, VIDEOTAPE, AND/OR COMPUTER IMAGES

I hereby consent that photographs, videotape, and/or computer imaging may be taken of me or of parts of my body under the following conditions:

Pre-treatment and post-treatment photographs will be taken of my treatment for medical record purposes. The photographs will be taken by my physician or staff member of my physician. I understand that these photographs will be the property of the attending dentist/ physician and Smiles at Reston Town Center.

Such photographs and/or videos shall be used only for medical records, teaching, publication, marketing, or scientific research by my dentist/physician and Smiles at Reston Town Center, provided that in any such publication the use of my name and identity is kept confidential and protected. Such photographs may be edited at the discretion of my physician to protect my confidentiality or emphasize a treated area.

» I have had the opportunity to discuss this consent with my attending physician or a qualified staff member of Smiles at Reston Town Center. I agree that all of my questions have been answered.

» I have read and fully understand this Photo/Video/Computer Imaging Consent and agree to all of its terms.

» I understand the photographs taken by my attending physician or any member of staff of Smiles at Reston Town Center are for my medical records only.

» I give consent for Smiles at Reston Town Center to use my photographs for teaching, publications, marketing, and/or research purposes. My name and identity shall be kept confidential at all times.

Signature: _____ Print Name: _____

Date: _____