Ocala Dental Care
OCALA DENTAL IMPLANT CENTER

Photo Release Form

I, _____, grant Ocala Dental Care and any associate affiliated with the practice permission to take photos of my face, mouth, and teeth before, during, and after treatment. I authorize Ocala Dental Care to use these photographs for the purpose of dental records, case discussion with lab entities, implant consults between affiliated representatives, marketing materials, and patient education. I understand that my photos will be used at my dentists' discretion; I do not expect compensation, financial or otherwise, for the use of these photographs.

I release Ocala Dental Care and its employees and legal representative from any and all claims, actions, and liability related to its use of said photographs.

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice. The authorization remains in effect unless written notice has been received by Ocala Dental Care effective starting this _____ day of _____, 20___.

Signature (Patient) _____

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