Permission to take Photographs and Digital Images (X-Rays)

Patient Name _____ Date_____

I do hereby authorize Dr. Yasaman S. Roland to take photographs and digital images (x-rays) of my face, jaws and the hard and soft tissues of my mouth.

I understand that these photographs and digital images (x-rays) will be a part of my permanent dental records.

I also understand that these photographs and digital images (x-rays) may be used for educational purposes in lectures, demonstrations, and professional publications and I hereby authorize said use.

Patient Signature _____ Date_____

Parent or guardian _____ Date_____
(If patient is a minor)

Staff Member _____ Date_____