TRUSMILE DENTAL

Consent for Dental Photography/ Videography

In view of the explanations given to me by my dentist.

I consent to my: (Please tick one or more boxes below)

- Photographs/videos being taken for my personal medical records only ☐
- Photographs/videos being used for educational purposes ☐
- Photographs/videos being displayed for advertising and display purposes ☐

The recorded material has educational, clinical and historical record keeping value. I consent to it being shown to appropriate professional staff.

Initial_____

The recorded material may be used in educational environments including professional and public meetings and via the internet. As a result, I understand that the general public may see the material. The material may be used in conjunction with other photographs, drawings, videos, sound recordings or forms of illustration. Should I request, every effort will be made to conceal my identity, but confidentiality is not guaranteed.

Initial_____

I understand no fee is payable to me by any party involved, now or at any time in the future

Initial_____

I understand that should the material be seen in a public domain it may be recorded by others and it may not be possible to retrieve it or control further distribution.

Initial_____

I understand that it may be possible to identify me from the pictures though every effort will be made not to do so. The purposes of recording the material has been clearly explained to me in terms I have fully understood.

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I understand once given the consent cannot be retracted, although if you wish for us to stop using this material, we will make every effort to do so immediately.

Full Name: _____ D.O.B_____
Date: _____

Signature: _____

Address:_____
_____
_____
_____
_____

Clinician's Name: _____ Date: _____

Signature: _____

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