CONSENT TO DENTAL PHOTOGRAPHY

I, _____ , authorize

Hanover Endodontics, LLC (Dr. Alkhalil and Dr. Agolli), to take photographs, and/or videos of my face, jaws and teeth, before, during and after treatment.

I consent to allow the photographs to be used for the following:

• Dental Records

• Dental Research

• Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books

• Marketing material, including websites and printed materials, patient education

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

☐ ***Check here if you do NOT want your full face shot used for any of the above purposes***

Signature (Patient) _____

Date _____