DENTAL PHOTOGRAPH/RADIOGRAPH RELEASE FORM

Patient Name: _____

I hereby consent that the dental radiographs ("x-rays") and/or dental Photographs made of me may be used by Dr. Hanson and his assigns.
I understand that these, if used, will be used only for the purposes of education and example representation (i.e. "before and after shots"), and that I will not be identified by name. I also understand that these may be used in-office, out-of-office, and/or on Dr. Hanson's web site, russellhansondentist.com

Patient/Guardian Signature:
_____
Date: _____

Check here if purposely not signed: ____