## DIAGNOSTIC RECORDS CONSENT

I, ________________________________ DOB:______________________
hereby authorise The Periodontists to take photographs, and videos of my teeth, jaws, and face. I understand that the photographs, and videos will be taken as part of my dental diagnostic records to ensure my periodontist is able to provide optimum care for my periodontal health.

Signed:

Date:

## MEDIA RELEASE CONSENT

This media may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures.

The content may also be used for advertising purposes (including website publication, Facebook posts, etc.)

I further understand that if the photographs, and videos are used in any publication or as part of a demonstration, my identifying information (first name only) could be used unless stated differently below.

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

If I wish to revoke this consent, I may do so in writing.

Please choose one option (if declining the 'Media Release Consent', leave blank and sign):

- ☐ I do not mind if any media is used in any of the above stated situations.
- ☐ I only agree to have my teeth shown without any identifying features.

Signed:

Date: