**Angela B. Bateson, DDS**

General Dentistry

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**PHOTOGRAPHY MODEL RELEASE FORM**

Title:

Last Name:

First Name:

Birthdate:

I hereby authorize Dr. Angela Bateson to take photographs, slides, and/or videos of my face, jaws, and teeth.

I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals). These images may include full-face portraits and close-up views of teeth.

I further understand that if the photographs, slides, and/or videos are used in any publications or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Patient (Or legal guardian) Signature: Signature Date:

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