PHOTO RELEASE

I consent and agree that Stonebridge Dental, its employees, and/or agents have the right to take photographs, video, or digital recording of me or my dependent and to use these in any and all media, including educational materials. (Social Media, Website, before/after photos etc).

I further consent that my name and identity may be revealed by descriptive text or commentary.

(Mark your choice below)

____Teeth Only

____Teeth & Face

____ I DO NOT give consent for Stonebridge Dental to release any media outside of the office.

I understand that there will be no financial or other remuneration for recording me, either for initial or subsequent transmission or playback.

Patient Signature Date

CONSENT TO ELECTRONIC COMMUNICATION

Unencrypted email is not a secure form of communication. There is some risk that identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. We will use the minimum necessary amount of protected health information in all communications.

_____ I consent and accept the risk in receiving information through email.

_____ I consent only to receiving appointment reminders and recall via email.

_____ I DO NOT consent to receiving any information through email.

Patient Signature Date